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March 22, 2006

VIA Electronic Mail and Hand Delivery

Board of Directors, Dirigo Health Agency
Attn: Lynn Theberge
Dirigo Health Agency
53 State House Station
Augusta, Maine 04333-0053

In Re: Determination of Aggregate Measurable Cost Savings
For The Second Assessment Year (2007)

FILING COVERSHEET

Dear Ms. Theberge:

Enclosed for filing please find the following:

SUBMITTED BY:	Christopher T. Roach
DATE:	March 22, 2006
DOCUMENT TITLE:	Anthem Health Plans of Maine, Inc.'s Exhibit List
DOCUMENT TYPE:	Exhibit List
CONFIDENTIAL:	**NO**

Thank you for your assistance in this matter.

Very truly yours,

Christopher T. Roach

cc: William Laubenstein, Esquire
William Stiles, Esquire
Bruce Gerrity, Esquire
D. Michael Frink, Esquire
Joseph P. Ditre, Esquire
Kelly Turner, Esquire
James Smith, Esquire

{W0464650.1}

STATE OF MAINE
DIRIGO HEALTH AGENCY

IN RE:	)	
	)	
DETERMINATION OF AGGREGATE MEASURABLE COST SAVINGS FOR THE SECOND ASSESSMENT YEAR (2007)	)	ANTHEM HEALTH PLANS OF MAINE'S EXHIBIT LIST

Pursuant to the Board of Directors of the Dirigo Health Agency's ("DHA Board") Procedural Order No. 3 dated February 22, 2006 ("Procedural Order"), Anthem Health Plans of Maine, Inc. d/b/a/ Anthem Blues Cross and Blue Shield ("Anthem BCBS") files this list of exhibits it intends to, or may, present or otherwise rely on in support of its direct case. Anthem BCBS maintains its objection that requiring the intervenors to designate witnesses and exhibits, provide witness testimony and exhibits, produce documents, designate experts and describe their alternative methodologies to determine aggregate measurable cost savings prior to the DHA presenting any meaningful data concerning its proposed methodology does not comport with the fair process requirements for an adjudicatory hearing conducted in accordance with the Maine Administrative Procedures Act. Subject to and without waiving those objections, Anthem BCBS provides the following exhibit list.

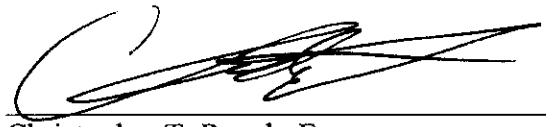
EXHIBIT NO.	DOCUMENT DESCRIPTION	PAGE NO.S	CONFIDENTIAL ?	OFFERED	ADMITTED
1	Prefiled Testimony of Sharon Roberts		No		
2	Prefiled Testimony of Jack Keane		No		
3	Prefiled Testimony of William Whitmore		No		
4	Prefiled Testimony of Thomas Drottar		No		
5	Maine Unit Cost and Utilization Charts		No		
6	Article: *Health Spending Projections through 2015: Changes on the Horizon*		No		

The exhibits Anthem BCBS's presents in its direct case in this proceeding will depend largely on the documents and information requested for production by the intervenors in their respective Freedom of Access Act ("FOAA") requests propounded on DHA. To date, many of the documents responsive to the requests have not been made available to the intervenors, including key data currently in the possession of the DHA's consultants, including Mercer Government Human Services Consulting ("Mercer"). The production of all documents responsive to the requests, including those currently in the possession of Mercer, is both prerequisite to the intervenors' ability to adequately explore, critique, and determine the reasonableness of the methodology proposed by the DHA, and, for those intervenors intending to present an alternative methodology, necessary to the development of those methodologies.

Because the scope of Anthem BCBS's direct case is subject to change with the rolling production of materials responsive to the intervenors' FOAA requests, Anthem BCBS cannot

now produce all documents it may utilize at hearing. Accordingly, in addition to the above materials, Anthem BCBS reserves the right to present at hearing any document produced in the first year assessment hearings conducted by the Superintendent of Insurance (In re Review of Aggregate Measurable Cost Savings, Docket No. INS-05-700), any document responsive to the Freedom of Access Act ("FOAA") requests propounded by Anthem BCBS and the other intervenors on DHA and the DHA Board, and any other documents or information produced in this proceeding subsequent to the date of this filing, and any summaries of information derived from any of the above sources. Anthem BCBS also reserves the right to present at hearing any exhibit or document designated for use by other parties to this proceeding.

DATED: March 22, 2006



Christopher T. Roach, Esq.

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Anthem Health Plans of Maine, Inc.

Certificate of Service

I, Christopher T. Roach, Esq. certify that the foregoing Anthem Health Plans of Maine, Inc.'s Exhibit List was served this day upon the following parties via U.S. and Electronic Mail.

Board of Directors, Dirigo Health Agency Attn: Lynn Theberge Dirigo Health Agency 53 State House Station Augusta, Maine 04333-0053	D. Michael Frink, Esquire Curtis Thaxter Stevens Broder & Micoleau LLC One Canal Plaza P.O. Box 7320 Portland, ME 04112-7320
Dirigo Health Agency Attn: James Smith, Esquire—Hearing Officer 53 State House Station Augusta, Maine 04333-0053	William Stiles, Esquire Verrill Dana LLP One Portland Square P.O. Box 586 Portland, ME 04112-0586
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Kelly Turner, Esquire Office of the Attorney General 6 State House Station Augusta, ME 04333-0006	Bruce Gerrity, Esquire Preti, Flaherty, Beliveau, Pachios & Haley LLP 45 Memorial Circle P.O. Box 1058 Augusta, ME 04332-1058

Dated: March 22, 2006

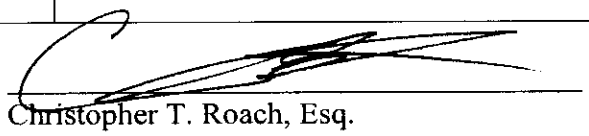

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Exhibit 1

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March 22, 2006

VIA HAND DELIVERY
Board of Directors
Attn: Lynn Theberge
Dirigo Health Agency
53 State House Station
Augusta, Maine 04333-0053

In Re: Determination of Aggregate Measurable Cost Savings
For The Second Assessment Year (2007)

FILING COVERSHEET

Dear Ms. Theberge:

Enclosed for filing please find the following:

SUBMITTED BY:	Christopher T. Roach
DATE:	March 22, 2006
DOCUMENT TITLE:	Non-Confidential Version of Prefiled Testimony of Sharon Roberts
DOCUMENT TYPE:	Prefiled Testimony
CONFIDENTIAL:	**NO**

Thank you for your assistance in this matter.

Very truly yours,

Christopher T. Roach

cc: William Laubenstein, Esquire
William Stiles, Esquire
Bruce Gerrity, Esquire
D. Michael Frink, Esquire
Joseph P. Ditre, Esquire
Kelly Turner, Esquire
James Smith, Esquire

NON-CONFIDENTIAL

STATE OF MAINE
DIRIGO HEALTH AGENCY

IN RE:	)	EXHIBIT 1
	)	
DETERMINATION OF AGGREGATE	)	
MEASURABLE COST SAVINGS FOR	)	PREFILED TESTIMONY OF
THE SECOND ASSESSMENT YEAR	)	SHARON ROBERTS
(2007)	)	
	)	
Docket No.	)	
	)	March 22, 2006
	)	

NON-CONFIDENTIAL

Q. Please state your name and your position with Anthem Health Plans of Maine, Inc., d/b/a Anthem Blue Cross and Blue Shield ("Anthem BCBS").

A. My name is Sharon Roberts. I am Director of Stakeholder Relations with Anthem BCBS in its Maine office.

Q. Please describe any relevant experience that qualifies you as a witness in this proceeding.

A. In addition to my 30 years of experience in the Maine insurance markets, I was appointed as a member of the working group formed pursuant to the Dirigo Health Act ("Dirigo Health" or the "Act") for the purpose of making recommendations for an appropriate methodology for calculating the "aggregate measureable cost savings . . . as a result of the operation of Dirigo Health." 24-A M.R.S.A. § 6913(1). I also participated in the first year assessment hearings before the Bureau of Insurance by preparing prefiled testimony and testifying at the hearing on the Bureau's review of the savings calculation and methodology proposed by the Dirigo Board.

Q. Please explain why Anthem BCBS intervened in this proceeding

A. Anthem BCBS is the largest health insurer in the State of Maine and also provides administrative services for a number of self-insured employers in Maine. By operation of the Dirigo Health Act, whatever savings are ultimately approved will determine one of the maximum limits for the savings offset payment ("SOP") to be paid by, among others, insurers like Anthem BCBS and then included in the premium rates and health claims that our members pay for their insurance. Anthem BCBS fully supports the goals of Dirigo Health and the objectives envisioned by the Act. In the interests of its group and individual members, however, Anthem BCBS is committed to ensuring that the amount of the SOP

reflects only the aggregate measurable savings permitted by the Act. The issues surrounding Dirigo Health are complex, but it is critical that the established methodology for calculating savings does not result in a savings offset payment assessment beyond the true savings that resulted from the operation of Dirigo Health.

Q. What is the purpose of your testimony?

A. Within the context of our reasons for intervening, there are several purposes to my testimony here today: (1) to explain how premium rates are calculated and the necessary implications of the SOP on those premium rates for our members; (2) to explain the principles and standards by which Anthem BCBS suggests the aggregate measurable savings should be measured, within the context of the Superintendent's Decision and Order approving an aggregate measurable cost savings figure for the first assessment year; (3) to explain how the DHA Board's methodology during the first assessment year deviated from those principles; and (4) to provide an alternative methodology that in our view more fairly calculates the aggregate measurable savings as a result of the operation of Dirigo Health.

Q. Why do you feel it is important to explain how Anthem BCBS calculates premium rates?

A. Because there apparently remain misconceptions about the way "savings" – whether as a result of the operation of Dirigo Health or not – flow to Anthem BCBS and then on to the ultimate consumers. Those misconceptions resulted in some suggesting that insurers, like Anthem BCBS, retained the "savings" from Dirigo Health and then refused to return those savings to consumers by passing through the savings offset payment, rather than absorbing this additional cost. It is unclear how widespread this fundamental misconception is, but the issues

surrounding Dirigo Health are important to the State, its residents, and Anthem BCBS's members and it is critical that all understand the basics of rate-setting so that all can maintain focus on the relevant issue: the amount of the aggregate measurable savings as a result of the operation of Dirigo Health that fall within the parameters of the Act.

Q. What happens to actual cost savings that result from the operation of Dirigo Health?

A. Mr. Whitmore explains the details in his testimony, but in short, those savings are included in the calculation of the premium rates that our members pay.

Q. How can members be assured that cost reductions that result from the operation of Dirigo Health are reflected in premium rates and not simply retained by Anthem BCBS?

A. Anthem BCBS is regulated by the Maine Bureau of Insurance – the same Bureau of Insurance that reviews the DHA Board's recommended calculation of the aggregate measurable cost savings as a result of the operation of Dirigo Health. As part of the regulatory process, the Bureau of Insurance regularly reviews Anthem BCBS's finances and, whenever Anthem BCBS seeks a rate modification for its individual products (*e.g.*, HealthChoice), the Bureau of Insurance examines every component of the proposed premium rates to ensure that they are reasonable. The Superintendent most recently examined these components in the late Fall of 2005, finding that all savings attributable to Dirigo were embedded in the premium rates Anthem BCBS proposed in that proceeding. *See, e.g.*, Docket No. INS-05-820, *In re Anthem Blue Cross and Blue Shield 2006 Individual Rate Filing for HealthChoice and HealthChoice Standard and Basic Products*, Decision and Order issued December 19, 2005, p.10 ("[Mr.

McCormack] testified that he was confident that the current contracts with healthcare providers were the best contracts that Anthem could secure and that embedded in those contract rates were the savings attributable to Dirigo. Furthermore, Mr. Whitmore [Anthem BCBS's actuary] testified these savings attributable to Dirigo had been incorported into the filed rates. The Superintendent concludes that Anthem has made best efforts to ensure recovery of the savings offset payment through negotiated reimbursement rates with health care providers that reflect the health care providers' savings as a result of Dirigo health care initiatives.")

Q. If the cost savings attributable to the operation of Dirigo Health are included in the calculation of premium rates, would it make sense to prohibit insurance carriers and third party administrators from including the savings offset payment in premium rates?

A. No, that would not be fair or logical because it would amount to double-dipping on the cost savings. Every dollar of cost savings from the operation of Dirigo Health that flow from the healthcare provider to the insurance carrier results in a one dollar reduction in premium rates. Under the current methodology for funding Dirigo Health, that same dollar is included as part of the savings offset payment initially paid by the carrier or third party administrator, and is thereafter added to the premium rates paid by those with private insurance, including Anthem BCBS's members. In this way, there is no cost impact on the insured member because every dollar of premium increase in the form of the SOP is offset by a dollar of cost savings that acted to reduce the member's premium rate.

Q. What did you mean that prohibiting insurers and third party administrators from including the SOP amount in premium rates would be "double-dipping" on the cost savings?

A. What I mean by double-dipping is that the Dirigo program is supposed to be self-funded by savings from the operation of Dirigo Health. Period. If the cost savings benefit those with private insurance in the form of lower premium rates, but instead of offsetting those reductions with the SOP, private insurance companies and third party administrators are prohibited from including the amount of any SOP in those same premium rates, those same insurance carriers and administrators – not Dirigo cost savings – will be used to fund Dirigo. So in effect, using my example of $1 in savings, the members would get the $1 in savings and the insurance carriers and administrators would pay the $1 SOP, which means there would be $2 in reductions (*i.e.*, $1 in premium reductions + $1 paid to fund Dirigo) for every $1 of cost savings from the operation of Dirigo Health.

Put another way, to the extent that Anthem BCBS obtains cost savings as a result of the operation of Dirigo Health in the form of lower provider contract rates, Anthem BCBS then passes those savings on to members in the form of reduced premium rates. If Anthem BCBS then pays an SOP equivalent to those cost savings, but is prohibited from including that amount in premium rates, Anthem BCBS (and other carriers and administrators), rather than Dirigo cost savings, would be funding Dirigo Health. That is not within the letter or spirit of the Dirigo Act.

The bottom line is this: suggesting that Anthem BCBS continue to pass through 100% of any cost savings, but somehow "absorb" the SOP, would be unfair, illogical and defy common sense. That was never the intent of the Legislation, nor would any reasonable businessperson expect that Anthem BCBS would have agreed to do so. *See, e.g.*, *In re Review of Aggregate Measurable Cost Saving Determined by Dirigo Health for the First Assessment Year*, Docket INS-05-700, Prefiled Testimony of David Wakelin, p.4 ("Of course, employers would like the insurance carriers and self-funded plans to absorb the SOP, but how can they? The carriers' profits have traditionally been limited in Maine. Is it reasonable that they would reduce that limited profit by a 4% SOP assessment and potentially operate at a loss? I think not. Unfortunately, that is not required in the Dirigo statute either. It is a utopian dream to expect the SOP assessment to be absorbed by the

insurance carriers, and it is not happening in the market. Looking then at self-funded plans, those plans are required by ERISA to operate without any profit at all. How can they absorb the SOP assessment? They must pass it on to employers and participants.")

Q. If health insurance carriers, including Anthem BCBS, are reimbursed for the savings offset payments by consumers because the payments will be embedded in premium rates, why is Anthem BCBS concerned with the amount of the savings offset payments?

A. Anthem BCBS remains concerned with the methodology that was adopted last year for calculating the savings because, in our view, the methodology was flawed and tends to overstate cost savings. Anthem BCBS works diligently to keep insurance costs for its members as low as possible. Anthem BCBS's members ultimately pay the SOP and that payment should not exceed the actual measurable aggregate cost savings as a result of the operation of Dirigo Health. That is the only way to ensure that existing insurance purchasers are not being unduly burdened by a new cost to subsidize Dirigo Health insurance coverage and that there will continue to be broad-based support for the ongoing operations of Dirigo Health and the subsidies for the health insurance coverage provided through the Dirigo Health Agency and Anthem BCBS.

Q. What is wrong with those who can afford health insurance subsidizing those who cannot?

A. Healthcare costs in Maine are already high. Each year during the regulatory process associated with examination of rate modifications for Anthem BCBS's HealthChoice products, the Superintendent hears from many Mainers who report their frustration with the continued rise in the cost of healthcare and health insurance in Maine and their need to make decisions whether they can afford to maintain insurance coverage. Requiring those with private insurance to pay an SOP that is inflated beyond the actual savings as a result of the operation

of Dirigo Health is an unfair burden and promises only to result in more Mainers dropping their coverage. As I testified last year in the proceeding before the Bureau of Insurance to review the Board's recommended calculation of aggregate measurable savings for the first assessment year, research shows that for every 1% increase in health insurance costs, 300,000 people lose coverage nationwide. That represents a significant number of Maine people who could drop coverage due to increased cost. If the savings offset payment represents new spending by purchasers that is not offset by tangible savings to them, the net impact to the system will result in more Mainers losing coverage because of the added cost rather than meeting Dirigo Health's intended goal of expanding coverage.

Q. How should the Dirigo Board calculate the aggregate measurable savings?

A. The Board should include only those savings that are within the language of the Act iself. The Act directs that the calculation should be limited to "the aggregate measurable cost savings, including any reduction or avoidance of bad debt and charity care costs to health care providers in this State as a result of the operation of Dirigo Health and any increased enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004." 24-A M.R.S.A. § 6913(1).

Q. Have you reveiwed the methodology that has been proposed by DHA for the Second Assessment Year?

A. The Procedural Order for this proceeding required all of the parties to designate witnesses, provide summaries of their testimonies, and exchange documents on or before March 10, 2006. That same Order required the identification of proposed alternative methodolog[ies] for calculation of aggregate measurable cost savings on or before March 13. As such, it was implicit in the schedule that the DHA would provide sufficient details of its proposed methodologies in its witness summaries; otherwise, requiring the other parties to

identify alternatives to the DHA's methodology by the following Monday would make no sense. All of the intervenors, except Consumers for Affordable HealthCare, complied with all of these deadlines, including identification of potential alternative methodologies. Notwithstanding these requirements imposed by the DHA Board, the DHA itself failed to comply with the deadlines and was finally ordered by the Presiding Officer to identify its methodology by March 20, the original deadline ordered by the DHA Board for filing of prefiled testimony in this proceeding. The DHA did make this late filing on March 20 and provided a report from its consultant, Mercer Government Human Services Consulting ("Mercer"), summarizing the methodologies that Mercer proposes should be used for calculation of aggregate measurable cost savings in the second assessment year (the "Mercer Report"). Citing incomplete data, Mercer suggests that it would be "impossible" to perform the calculations under the methodology it proposes. Although the Mercer Report reflects that the vast majority of the data applicable to Mercer's proposed methodologies is "currently available", DHA provided no data or documentation in support of the proposed methodologies.

The point of my recitation of these facts is to make clear that I have had access to the DHA's summary identification of its methodology for less than 48 hours before my own testimony had to be finalized so that it could be prepared for filing. As such, while I have read the DHA's summary identification of its methodology, I have had almost no time to give it more than a cursory review and had no access to any of the data that DHA has in its possession that supports its methodology and calculation. Depending on the type of data provided and the timeframe in which it is provided, it is unclear whether I will have a meaningful opportunity to review that data before the hearing. I also obviously have not reviewed the DHA's testimony in support of the methodology as it was not available to me at the time my testimony was prepared.

Q. Understanding that you have had only very limited time to review the DHA summary, do you have a sense of the methodology that DHA proposes for the second assessment year?

A. Yes, it appears that the DHA will rely heavily on the Superintendent's Decision and Order from the first assessment year. As such, although we have not yet had an opportunity to examine DHA's proposed methodology in any level of detail, we have provided in our witness testimonies our perspectives under the assumption that the DHA's methodology will track the Superintendent's Decision from the first assessment year. We will almost certainly have follow-up testimony to offer at the hearing once we have an opportunity to review DHA's proposal in more detail.

Q. Do you have any preliminary comments based on the methodologies summarized in the Mercer Report?

A. Yes, I have several preliminary comments. First, at page 3, the Mercer Report suggests that "[r]educing the rate of increase in the cost of services reduces the need for payer rate increases and results in savings to the entire health care system." They also say "the savings will be used to sustain DirigoChoice at no additional costs." (*See* Mercer Report, p.9.)

I would definitely agree that this is how the Dirigo Legislation is supposed to work: hospital costs are reduced by the operation of Dirigo Health; hospital charges to insurance carriers are reduced correspondingly to reflect those lower costs; the carriers pass along those reduced charges to members in the form of lower premium rates; the carriers pay a savings offset payment to offset those reduced charges from hospitals; and the savings offset payment amount is included in premium rates to complete the circle so that, under that process, no party bears the burden of funding Dirigo. It is, instead, funded entirely from savings that the program has created.

Q. So what is wrong with the statements in the Mercer Report?

A. The statements caught my eye as I read the Mercer Report because the methodology that Mercer and the DHA Board insisted upon last year explicitly severed the connection between cost reductions and charge reductions that is implicit in the statements in this year's Mercer Report. Later in the report, Mercer suggests the same type of "cost based" analysis this year, thereby ignoring whether any of the calculated "savings" actually innure to the benefit of those private payers who will be assessed the savings offset payment. The only way to insure there are "no additional costs" as Mercer suggests, is to develop a methodology that measures whether the SOP-payors' costs are reduced. The Mercer methodology does the opposite; counting all reductions in hospital costs and ignoring whether those reduced costs resulted in reduced hospital charges, which ultimately lead to reduced premiums.

As set forth in Mr. Keane's prefiled testimony, we strongly urge the DHA Board to reconsider this disjointed approach and adopt a methodology that measures the hospitals' charges because it is only through a reduction in the growth of hospitals' charges that the symbiotic relationship suggested by Mercer's statement can actually exist. Without that connection in the methodology, Mercer's words do not translate into a reasonable methodology for measuring cost savings that actually reach insurers or their customers.

Q. What is your next preliminary comment on the Mercer Report?

A. The Mercer Report in several places indicates that "interest will be applied to the savings amount to put it on a consistent time period with the other savings calculations." (*See, e.g.*, Mercer Report, p.3) Although I am unsure of the precise meaning of these words because we have not yet seen from DHA an aggregate savings calculation, if this means that Mercer is suggesting that those who will

pay the SOP should also pay interest on the calculated savings, I think that would exacerbate the fundamental flaws in Mercer's proposed methodologies. As I indicated above, the Mercer proposal severs the connection between the aggregate measurable savings calculation and the ultimate payors of the SOP, which means that there is no protection to ensure that private payors are paying an SOP that is no larger than the cost savings that they have received in the form of reduced hospital charges and correspondingly reduced premiums. Requiring those private payors to pay for phantom "savings" is wrong; adding interest to those phantom savings adds insult to injury.

It is no answer to suggest, as Mercer has, that we need not worry because their methodologies are "conservative." (*See* Mercer Report, p.13.) One need only recall Mercer's initial first year calculation of $233 million, which was ultimately reduced to $43.7 million by the Superintendent, to refute the suggestion that the savings calculation under the Mercer proposal will be no larger than the amount of savings that innure to the benefit of the private payers, nor to ensure that private payers are not paying for "savings" that have benefited governmental, not private, payers. The calculation is not set up to limit the resulting "savings" in that manner, nor are there safeguards to ensure that this legitimate ceiling on savings is not exceeded. Even if it were possible to replicate the precise cashflow and time value of money calculations with meaningful accuracy (which is highly doubtful), adding interest to the mix would exaggerate an already inflated calculation.

Q. What is your next preliminary comment on the Mercer Report?

A. Mercer suggests that one of its "Guiding Principles" is that "the methodology must be reasonable and appropriately measure the impact of Dirigo on the rate of growth in the health care system." (Mercer Report, p.8.) Mercer conceded in the last proceeding that it does no analysis to determine what factors influenced the observed expense growth and it is not apparent from the Mercer Report that they are

recommending any modifications to that approach. It is unclear to me how the Mercer methodology can measure the impact of Dirigo when it does no analysis that attempts to isolate any causative factors, much less isolate that part of the calculated "savings" that resulted from the operation of Dirigo Health. I agree that should be a guiding principle; I just do not see how the proposed methodology adheres to it.

Q. Do you have any other preliminary comments on the Mercer Report?

A. Yes, one final preliminary comment. In its summary description of the calculation of Mainecare expansion, it appears that Mercer has not accounted for previously insured customers moving to Mainecare. Under that scenario, the hospital at which the Mainecare member seeks treatment actually experiences a decrease in revenue when compared to that same member seeking the same services when the member was privately insured. This occurs because Mainecare reimbursement rates are lower than the rates paid by private insurance carriers. Accordingly, the Mercer methodology would calculate "savings" when hospital revenues actually go down. Hospitals obviously cannot pass on as "savings" a reduction in hospital revenues.

Q. Have you now made all of your preliminary comments about the Mercer Report?

A. Yes, although as I testified earlier, I have had only very limited time to review the Mercer Report and have not seen any of the underlying data or calculations. I intend to review the Mercer Report and any follow-up information that DHA provides and will likely have supplementary testimony at the hearing.

Q. Has Anthem BCBS developed an alternative methodology for calculating cost savings that is more consistent with the Dirigo Act?

A. Let me start by saying that I am not a lawyer and am not offering legal opinions as to the meaning of the Dirigo Act or the types of savings that are within the language of the Act. I understand that those issues are on appeal and, depending on the outcome, could have a significant impact on the way in which cost savings have been, and will be, calculated. For the second assessment year, Anthem BCBS started with the Superintendent's Decision and Order from the first assessment year and, within the confines of that Decision, analyzed whether improvements to the methodology should be made.

With that contextual background, the answer to your question is, yes, we are proposing an alternative to the methodology that was approved by the Superintendent last year. Mr. Keane provides the details of the methodology in his testimony, but I will summarize our proposed alternative.

Q. Please go on.

A. One of the central flaws in the Board's cost per case mix adjusted discharge ("CMAD") calculation was its failure to recognize and take account of the fluctuations in hospital expenses that occur naturally year to year, and have nothing to do with the operation of Dirigo Health. *See, e.g., First Assessment Year Decision and Order*, Docket INS-05-700, p.12 ("Given that operating expenses per CMAD for any hospital fluctuate from year to year for a wide variety of reasons, it is unreasonable to assume that any decrease over the base period is due to the voluntary cost control while ignoring increases over the base period.") Indeed, as the Superintendent recognized, expenses are <u>expected</u> to fluctuate, and the historical data presented by the Board's and Consumers for Affordable Healthcare experts confirmed that fact.

Notwithstanding that this historical data showed that expense results are expected within a range or corridor, the Board's methodology relied upon the flawed premise that expected results were limited to a single point; if hospital expenses were "above" this straight-line approach, there was an "unexpected" increase in costs and those values were excluded from the cost savings calculation; if hospital expenses were below the line,

there was deemed an "unexpected" decrease in costs, which then were assumed to be caused by Dirigo Health and included in the cost savings calculation.

The fallacy with this approach is that many of these results were not unexpected at all, but rather well within the corridor of results that one would expect given the natural fluctuations reflected in the historical data.

The Superintendent attempted to lessen the impact of the Board's initial flawed approach by including the results for all hospitals. That is, the Superintendent aggregated all of the Board's CMAD calculations, whether they fell below or above the line the Board established as demarcating expected expenses. The Superintendent noted in his decision, however, that this was certainly not a perfect fix for the methodological flaw of assuming that hospital expenses are expected to increase in a straight-line projection, rather than fall within a range, or corridor, of expectations. Rather, "including both increases and decreases will *help* to cancel out the random fluctuations." *See, e.g., First Assessment Year Decision and Order*, Docket INS-05-700, p.11 (emphasis added).

Q. Was that the only foundational flaw in the Board's methodology?

A. No, in addition to duplication with other measures, the Board failed to investigate anomalous results of the methodology to determine the cause(s) of the anomaly and whether the calculated cost savings were, in reality, as a result of the operation of Dirigo Health. Indeed, neither the Board, nor its experts, even contacted the hospitals with the purported cost savings to inquire as to the cause(s).

Q. How does Anthem BCBS propose to correct these flaws in the methodology?

A. Let me start with our proposal to correct the "straight-line expectation" flaw. Our analysts started with the same historical data set used by the Board's experts and, from it, determined the expected range of cost growth for each hospital in Maine. We then

projected the corridor of expected costs using the market basket inflation index approved by the Superintendent in his decision and order in the First Assessment Year matter.

We then plotted each hospital's actual expense results against the corridor of expected results. Hospitals that experienced actual expenses within the expected corridor were excluded because expense growth kept pace with historical, pre-Dirigo expectations. Hospitals with actual expenses that were higher than the expected corridor were excluded as well. Hospitals with costs lower than the expected corridor were put into a group for further analysis.

Q. How does Anthem BCBS's proposed methodology remedy the flaw of including what are apparently anomalous results?

A. That is what I meant by the "further analysis" that I referenced earlier. Once the list of hospitals with potential cost savings (*i.e.*, those with expenses below the expected corridor) is identified, we propose two follow-ups to investigate results that are significantly below expectations. For its part, Anthem BCBS would examine our own contracts with these hospitals to determine whether we, Anthem BCBS, received a reduction in the growth of the hospital's contract rates that was consistent with the "cost savings" resulting from our corridor analysis. We also propose that the DHA should make outreach efforts to each of the targeted hospitals and question them on the factors that influenced their costs in the measuring period.

Q. Why do you believe this methodology is superior to the Board's CMAD methodology?

A. Two main reasons. First, our methodology is objectively superior because it accounts properly for the reality that hospital expenses fluctuate naturally and, as such, expected results are within a range, not a straight line. Second, our methodology verifies the results of the objective analysis by (1) reviewing real-life negotiated contract rates,

and (2) probing the hospitals with the purported cost savings to ensure that anomalous results, entirely unrelated to the operation of Dirigo Health, are not included in the cost savings calculation.

The irony of last year's calculation of the aggregate measurable costs is that the very hospitals that purportedly experienced all of the cost savings in the first place were largely ignored. They were not part of the proceeding and, after the Board calculated all of the "savings" for those hospitals with costs that were below the line, no-one asked them whether those calculations were consistent with reality and certainly not whether the purported cost savings were as a result of the operation of Dirigo Health.

Anthem BCBS's proposed methodology fixes that problem and brings a critical component – the hospitals with the purported cost savings – into the methodological loop so that we can avoid the absurd calculation of "cost savings attributed to Dirigo" that rely on assumed cost growth rates that are significantly out of line with the hospital's reasonable expectations, as was the case last year (*e.g.*, Mount Desert—41.72 %; Penobscot Valley—19.11%; Stevens—15.88%).

Q. Does Anthem BCBS's CMAD proposal calculate all of the cost savings as a result of the operation of Dirigo Health, or are there additional measures that should be used?

A. One of the additional problems with the Board's methodology from the first assessment year was that it used several measures, some of which were duplicative of others (*e.g.*, CMAD and CON), which resulted in double counting and an inflated cost saving calculation. Anthem BCBS's proposed methodology is designed to both capture the full amount of cost savings and verify that they are as a result of the operation of Dirigo Health.

As I have previously said, Anthem BCBS is fully supportive of the goals of Dirigo Health and wants the program to succeed. The funding of the program, however, must be done responsibly and in a way that does not result in an additional burden on those who

already pay a high price for healthcare insurance. The methodology Anthem BCBS proposes meets both of those goals and would ensure not only the continuation of the Dirigo program, but also public acceptance that the cost savings that they reimburse in their premium rates are real.

Q. Does this conclude your testimony?

A. Yes.

Certificate of Service

I, Christopher T. Roach, Esq. certify that the foregoing Prefiled Testimony of Sharon Roberts was served this day upon the following parties via U.S. and Electronic Mail.

Board of Directors, Dirigo Health Agency Attn: Lynn Theberge Dirigo Health Agency 53 State House Station Augusta, Maine 04333-0053	D. Michael Frink, Esquire Curtis Thaxter Stevens Broder & Micoleau LLC One Canal Plaza P.O. Box 7320 Portland, ME 04112-7320
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Dated: March 22, 2006

Christopher T. Roach, Esq.

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Exhibit 2

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March 22, 2006

VIA HAND DELIVERY
Board of Directors
Attn: Lynn Theberge
Dirigo Health Agency
53 State House Station
Augusta, Maine 04333-0053

In Re: Determination of Aggregate Measurable Cost Savings
For The Second Assessment Year (2007)

FILING COVERSHEET

Dear Ms. Theberge:

Enclosed for filing please find the following:

SUBMITTED BY:	Christopher T. Roach
DATE:	March 22, 2006
DOCUMENT TITLE:	Non-Confidential Version of Prefiled Testimony of Jack Keane
DOCUMENT TYPE:	Prefiled Testimony
CONFIDENTIAL:	**NO**

Thank you for your assistance in this matter.

Very truly yours,

Christopher T. Roach

cc: William Laubenstein, Esquire
William Stiles, Esquire
Bruce Gerrity, Esquire
D. Michael Frink, Esquire
Joseph P. Ditre, Esquire
Kelly Turner, Esquire
James Smith, Esquire

NON-CONFIDENTIAL

STATE OF MAINE
DIRIGO HEALTH AGENCY

IN RE:	)	EXHIBIT 2
	)	
DETERMINATION OF AGGREGATE	)	
MEASURABLE COST SAVINGS FOR	)	PREFILED TESTIMONY OF
THE SECOND ASSESSMENT YEAR	)	JACK KEANE
(2007)	)	
	)	
Docket No.	)	
	)	March 22, 2006
	)	

NON-CONFIDENTIAL

Q. Please state your name and your employer.

A. My name is Jack C. Keane. I am a consultant for Anthem BCBS. I operate my own health care consulting business. In addition to Anthem, my clients include or have recently included Independence Blue Cross (which is the BCBS plan for the metropolitan Philadelphia area); CareFirst BCBS (which is the BCBS plan for Northern Virginia, the District of Columbia, Maryland and Delaware); and, occasionally, hospitals and self-insured purchasing groups. Before becoming a full-time consultant, I held various jobs, including Director of the Bureau of Hospitals for the Massachusetts Rate Setting Commission, and Deputy Director of the Maryland Health Services Cost Review Commission. I also co-founded a company that established preferred provider organizations (PPOs) in approximately 60 cities throughout the U.S.

Q. Please describe any relevant experience that qualifies you as a witness in this proceeding.

A. I have nearly thirty years of exeprience in the health care field. My expertise is in the areas of health care finance, data analysis and provider contracting. I have done hospital negotiations in more than thirty states for a variety of clients including BCBS plans, commercial insurers and self-insured trust funds. I have also held senior positions for the state hospital rate setting programs in Massachusetts and Maryland where I was involved in developing or implementing state health legislation. I served as Anthem's acting Excecutive Director of provider contracting in Maine during 2003. I work regularly with the Anthem provider contracting and provider reimbursement services staff in Maine, New Hampshire and Connecticut.

Q. What is the purpose of your testimony?

A. The purpose of my testimony is to provide comments regarding the determination of the "savings offset payment" (SOP) and to describe a methodology for the estimation

of the hospital-related "aggregate measurable cost savings" (AMCS) that could be viewed as supporting an SOP for CY 2007, assuming that the cost savings measures are within the measures allowed by the Dirigo Act.

Q. Have you reviewed the Decision and Order filed by the Superintendent of Insurance pursuant to the adjudicatory hearing that was held last year regarding the First Assessment Year? In particular, have you reviewed the section that addresed the determination of the AMCS attributable to the hospital savings initiatives?

A. Yes. The Superintendent found $33.7 million of savings under the CMAD methodology and no savings under the COM measure.

Q. Before I ask your views of that CMAD methodology, are you testifying here about whether the Dirigo legislation allows CMAD savings to be included in the determination of aggregate measurable cost savings?

A. No, the question of what types of calculated "savings" are within the ambit of the calculation of aggregate measurable cost savings within the Dirigo legislation is a legal determination that I am not qualified to make. Instead, I am addressing the CMAD methodology within the Superintendent's Decision and Order and commenting on whether that methodology could be improved, irrespective of whether cost savings resulting from the calculation should, or should not, be included as savings that result from the operation of Dirigo Health under the Dirigo legislation.

Q. With that understanding, do you have comments regarding the methodology in the Superintendent's Decision and Order that are pertinent to the construction of a determination of hospital-related AMCS for the Second Assessment Year?

A. Yes. The Superintendent acknowledged that the methodology used by the DHA Board had significant weaknesses. In particular, the Superintendent found that the Board's inclusion of only those hospitals that had shown savings in its calculation of

aggregate savings was not reasonable. The Superintendent found that including both those hospitals with increases in expenses and those hospitals with decreases in expenses, relative to the targeted expense increases, was more reasonable because it would have a canceling effect that would be more likely to screen out non-Dirigo cost effects. *See, e.g.*, In Re Review of Aggregate Measurable Cost Savings, Docket No. INS-05-700, Decision and Order, p.11 ("Given that operating expenses per CMAD for any hospital fluctuate from year to year for a wide variety of reasons, it is unreasonable to assume that any decrease over the base period is due to the voluntary cost control while ignoring increases over the base period. While the increases cannot be attributed to voluntary cost control, including both increases and decreases will help to cancel out the random fluctuations.") I believe that the Superintendent was on the right track in suggesting that refinements to the methodology are appropriate and that the approach that is taken for the Second Assessment Year should incorporate some improvements.

Q. If your suggested improvements were adopted, will that remedy all of the problems you have identified with the methodology proffered by the DHA Board last year?

A. No, the methodology proffered last year made no effort to determine the cause of the calculated cost savings, much less whether they were as a result of the operation of Dirigo Health; did not address the fact that the increases and/or decreases in expense per CMAD fluctuate widely each year on a hospital-specific basis; would have produced savings in states clearly unaffected by Dirigo Health and for years prior to the enactment of the law; and focused on costs, rather than charges, even though it is charge levels, not cost levels, that are the primary driver of private sector payments in Maine. As a result, the methodology and its associated savings were rejected in part, and reduced in part, by the Superintendent. The improvements I am suggesting are not a perfect fix for these significant flaws, but they would significantly ameliorate what I see as the central problems in the methodology.

Q. Would you briefly describe the improvements that you would suggest?

A. Yes. First, however, before I describe my suggested improvements, I would like to note that for the sake of clarity I will use the term "Expense per CMAD" rather than the terms "CMAD" or "CMADs" in the following comments. The term CMADs is generally used in the hospital industry to refer only to the number of discharges, weighted by a casemix factor, rather than to costs.

The improvements that I am suggesting are of several types. I will discuss the first improvement here, regarding the establishment of a "corridor" against which to assess cost increases, and I will discuss the other two improvements, regarding the computation of outpatient visits, and the use of a charge-based CMAD measure, instead of an expense-based CMAD measure, later in this testimony.

Q. Would you please describe the first improvement?

A. Yes. The first improvement that I am suggesting follows the Superintendent's finding – with which I agree – that hospital expenses fluctuate naturally for a whole host of reasons. These fluctuations are especially pronounced in small hospitals like those that are predominant in Maine. Specifically, annual volume swings—i.e., increases and decreases in utilization—are especially large at small hospitals because they are usually serving relatively small populations. The frequency and type of illness (and, therefore, the need for medical services) fluctuate from year to year in all populations, and the fluctuations are especially large for relatively small populations. A substantial portion of hospital costs are "fixed" in that they do not vary up or down with utilzation levels. When volume goes up, hospitals can spread their fixed costs over larger amounts of utilization, and this reduces their expense per CMAD; and when volume drops, the hospitals have less ability to spread their fixed costs, and this increases their expense per CMAD. These volume-related cost increases and decreases, and cost changes associated with other factors, routinely occurred before Dirigo and they will continue to occur in the future. The methodology that DHA proposed last year, in which they defined a single point of

projected expense per CMAD for each hospital, counted all observations below this point as "savings," and ignored all of the observations where expense per CMAD exceeded the projected level, was not reasonable, and the Superintendent recognized this key flaw by requiring the previously cited "netting" of increases and decreases in his decision. The annual increases and decreases in expense per CMAD need to be assessed against the backdrop of the expected fluctuations in hospital expenses. My suggestion is to use a corridor approach to address this problem.

Q. What do you mean by a "corridor approach"?

A. By a "corridor approach" I mean that the methodology should compare the actual hospital-specific increases and decreases in Expense per CMAD in the post-Dirigo period to the historical range of increases and decreases in Expense per CMAD for those same individual hospitals in the pre-Dirigo period. To establish the baseline corridor of expected expenses, the annual increases and decreases in the Expense per CMAD for each hospital should be compared to the change in the Hospital Market Basket Index (HMBI) for each of those years. The HMBI measures the level of inflation in hospital costs per admission that is attributable each year to underlying changes in the costs of key resources (e.g., nurses, other technical and administrative personnel, medical supplies, drugs, etc.) used by hospitals in their production of medical services. The difference between the HMBI and the change in the Expense per CMAD should be recorded for each hospital for each pre-Dirigo year to establish the historical "corridor" within which these differences fell during the pre-Dirigo period. The corridor is the band or range of experience within which hospital expense per CMAD increases (and decreases) fell during the pre-Dirigo period. The corridor thus establishes the expected range of costs for each hospital unrelated to the operation of Dirigo Health.

For example, the pattern for a particular hospital might show that its actual increase in Expense per CMAD was 1.5 percentage points above the HMBI for 2001/2000; .5 percentage points below the HMBI for 2002/2001; and 1.0 percentage points below the HMBI for 2003/2002. The corridor for this hospital would be the HMBI plus 1.5 and

minus 1.0 percentage points. Thus, if the change in the Expense per CMAD for this particular hospital in the year to be used as the basis for an upcoming calculation of AMCS were 1.5 percentage points below the HMBI for that period, then it might be reasonable to consider this .5 percentage point difference between the actual change and the "low" side of the corridor as the starting point for identifying the savings that occurred in that year as a result of the operation of Dirigo Health.

Q. Why do you believe your "corridor" approach would be an improvement in the calculation of the CMAD savings?

A. The corridor approach would identify changes in the Expense per CMAD that are outside the normal range of pre-Dirigo flutuations in hospital expenses. As I noted above, these fluctuations have historically been quite large and can reasonably be expected to be just as large in the future. These deviations have been driven by many factors—including year-to-year changes in volume levels—that are undoubtedly more powerful than Dirigo in affecting annual expense trends at many hospitals in Maine. These factors, along with the operation of Dirigo Health, will influence hospital cost trends in the future. Therefore, any methodology that labels the entire difference between a predicted, hospital-specific Expense per CMAD in any particular year and the actual Expense per CMAD in that year as Dirigo-related "savings" is not reasonable, especially if it ignores the results for hospitals with higher than predicted levels of Expense per CMAD. The Superintendent agreed that such a methodology was not appropriate, and therefore required that the savings for 2004 be counted on a "net" basis that included the Expense per CMAD results for all hospitals. The corridor approach explicitly addresses the fact that hospital expenses are not expected to increase in a straight line relationship with the HMBI, but are instead expected to fluctuate substantially from year to year. The corridor approach takes these fluctuations into account by focusing on those results that are outside the normal range of fluctuations that are associated with hospital expense levels.

Q. How does your suggested corridor methodology differ from and improve on the Superintendent's modified approach?

A. The Superintendent's requirement that all hospitals be included in the savings computation was far superior to including only those with expenses that fell "below the line," but it only addressed the issue of fluctuations in Expense per CMAD in an oblique manner. Specifically, in effect it treated all of the differences between the predicted Expense per CMAD and the actual Expense per CMAD in the relevant year as equally credible. This "netting" requirement that was imposed by the Superintendent had the "canceling" impact that I referred to above in my testimony. However, I would modify the Superintendent's approach to explicitly address the fluctuation problem by treating only those differences that are outside the historical corridor that I described above as credible. Only those differences between the actual and expected Expense per CMAD that fall outside the corridor (*i.e.*, those results that are truly unexpected and different from the pre-Dirigo experience) would be considered for further evaluation in the savings estimation. In fact, as I will discuss more fully below, I would not count observations that fall above the corridor against Dirigo, and I would identify for further review and verification those cost observations that fall below the corridor with the purpose of determining which of these savings were and were not Dirigo-related savings.

Q. Would you keep adding years to the historical corridor against which more recent experience would be compared?

A. No. Specifically, I would not add post-Dirigo years to the corridor. By stopping with the last year of experience recorded before Dirigo took effect, it is possible to capture the fluctuations that typically occurred before the operation of Dirigo Health was a confounding factor. This approach provides a pre-Dirigo benchmark from which we can derive the corridor of expected vs. actual Expense per CMAD for each hospital. I also would not go back and add additional pre-Dirigo years (*i.e.*, years prior to 2000) because the addition of more years will inevitably expand the corridor and incorporate more extreme results into it. Eventually, it would be necessary to impose some bands on

the observations included in the corridor or virtually all future observations would fall within it and no savings would be attributed to Dirigo. Therefore, I would rely on a corridor based on the data that was submitted by DHA's witnesses in last year's hearing.

Q. Have you examined any data and have you constructed an example of a corridor-based analysis of Expense per CMAD patterns?

A. Yes. The necessary historical data was produced in last year's hearing by the DHA witnesses, so I was able to calculate the historical corridor using that data. Data for 2005 had not yet been produced at the time I performed this analysis, so I used the 2000 to 2004 data that the DHA Board experts provided last year to perform an example analysis. Specifically, I took the Expense per CMAD data submitted at the previous adjudicatory hearing by DHA on a hospital-specific basis for the years 2000 through 2004 and I compared the year–by-year changes in those expenses to the HMBI increases for those same years. I established the historical corridor for each hospital based on its actual increases (or decreases) in Expense per CMAD for 2001/2000, 2002/2001 and 2003/2002 compared to the HMBI for those same years. After establishing the hospital-specific corridors, I calculated the positive (or negative) difference beween the hospital's actual change in expense per CMAD in 2004 versus the HMBI for 2004. Finally, I compared this difference to the hospital's corridor to determine whether the 2004 experience was inside or outside the corridor. I ignored differences that fell within the corridor because they were not dissimilar from differences that had occurred prior to Dirigo, *i.e.*, those results fell within the range of fluctuation that was predicted based on the historical trend data for the particular hospital. Although an argument could be made for further analysis, I also ignored differences that fell on the "high" side outside the corridor on the grounds that I have seen no evidence that Dirigo has had the effect of materially raising hospital costs above the levels that would otherwise have occurred. I counted all of the observations that fell outside the corridor on the low side as potential savings that could be attributed to the operation of Dirigo Health. These savings should

be subjected to some additional review and verification to determine whether they are partially or wholly Dirigo-related savings.

Q. Without performing any further analysis of the cause of the lower than expected expenses, what level of cost savings did this approach produce for 2004?

A. If we assumed that 100% of the observations that fell oustide the corridor on the low side were savings that could reasonably be deemed to have occurred as a result of the operation of Dirigo Health for 2004, the potential savings across all payers (governmental and private) would have amounted to $10.8 million.

Q. Should the entire $10.8 million of aggregate savings that you found using the corridor methodology be included in the SOP?

A. No. The $10.8 million represented savings across all payers. The private payers in Maine cover approximately 40-50% of all patients. Therefore, under my approach, I would include only 40-50% of the $10.8 million as potential savings in the SOP.

Q. Do you think that all of the low observations that you counted as savings in the preceding example should be automatically counted as Dirigo-related savings?

A. No. As stated above, I think that it would be worthwhile to investigate savings that are extraordinarily large to determine whether they should be attributed to the operation of Dirigo Health. It will be extremely difficult, if not impossible, to precisely disentangle extraordinary from ordinary events. However, some events are so anomalous that they could be readily identified as ones that should disqualify, or result in modification of, the potential savings. Citing a lack of time and administrative difficulty, the DHA Board consultants in the last proceeding took no steps to verify that the cost savings that were identified at particular hospitals resulted from the operation of Dirigo

Health. I believe it is important to do some further review and verification of identified savings on a hospital-specific basis. As I described above, in small hospitals—which are the predominant type of hospital in Maine—volume swings can have substantial impacts on Expense per CMAD levels in any given year and on trends across a series of years. It is important for the Dirigo savings estimate to be credible. In my opinion, the goal of credibility requires the screening out of cost reductions, such as those that were driven by large volume changes, that were probably not Dirigo-related.

Q. Would you more specifically describe the approach that you are suggesting for the hospital-specific reviews?

A. Yes. First, as explained above, I would not count cost increases that are above the corridor against Dirigo, so only those hospitals with savings would be of any concern. Second, I would restrict the hospital-specific reviews to those hospitals with cost savings relative to their corridor. The most important issue to pursue in the verification of these savings would be to determine whether or not the hospitals with apparent savings had experienced large volume increases. Large volume increases enable hospitals to substantially increase their spreading of fixed costs, and this increased spreading has the effect of reducing average cost and lowering the change in Expense per CMAD from the previous period. These volume-related savings would not be appropriately counted as Dirigo-related savings. Other non-Dirigo cost influencing factors might also be identified in the verification process but, in my opinion, the effects of volume increases would be the chief matter for review.

Q. Would it be feasible to contact the hospitals identified as having savings and to make a determination as to whether those savings should be included, in whole or in part, in the estimation of savings as a result of the operation of Dirigo Health?

A. Yes, I believe it is feasible. As explained above, the corridor approach would remove from further review all hospitals whose change in expense per CMAD fell (a)

within the corridor and (b) outside the corridor on the high side. Based on the previously-cited data for the 2001 through 2003 period, this approach would identify approximately ten (10) hospitals for additional review. The attention given to hospitals with small savings could be commensurately limited in scope and effort. I expect that the number of hospitals that would need further review under this approach, if all hospitals with savings relative to the corridor were to be reviewed, would be limited to approximately ten (10) per year with the level of review scaled to the size of the apparent savings.

Q. Do you believe your proposed methodology would produce a more accurate estimate of cost savings?

A. Yes. The proposed methodology incorporates an empirical analysis that uses historical data that has already been presented by DHA and accepted by the Superintendent and it recognizes that expenses for hospitals will fluctuate naturally within a corridor or range of historical experience. The Superintendent identified the failure to recognize these fluctuations as a flaw in the DHA Board's methodology. The Superintendent found that the savings claimed by Dirigo were much too high and he imposed a much more reasonable approach. I believe my suggested approach refines the approach that was approved last year by specifically addressing the fluctuations problem in a systematic way using readily available data. It also provides for further review of potential savings to determine whether they are Dirigo-related without extensively miring the process in detailed and highly subjective hospital-specific reviews.

Q. Won't your proposed methodology take more time?

A. I do not believe that my approach would take more time, even if a small number of hospital-specific inquiries are needed, because the needed computations would be straightforward and the associated review effort could be focused on those hospitals with especially large savings beyond their corridor. My approach would be very likely to

screen out the enormous and poorly supported savings that were originally presented by the DHA Board in last year's hearing and which were dramatically reduced in the review process. One need only consider that the Dirigo Board methodology first calculated savings at over $233 million, then at $137 million, then at $110 million, and that the savings were finally reduced by the Superintendent to $43.7 million, to realize that a lot of time and energy went into the review process. Much of the time and effort spent in debunking the initial and revised savings claimed by the DHA Board could have been avoided by adopting my suggested approach.

Q. What data would you need to establish the "corridor" analysis described above for the second assessment year?

A. The data that would be needed for a corridor-type Expense per CMAD test have been identified in the Freedom of Access Act (FOAA) data request filed by Anthem BCBS with DHA on February 28, 2006. Based on my review of the Dirigo Health Savings Offset Payment: Year 2 – Methodology and Data Sources (the "Mercer Report"), the vast majority of the requested information is already compiled and available to DHA. In fact, the data needed to compute the savings under my methodology for the year two Expense per CMAD calculation are already available to the DHA for approximately 75% of the hospitals. The DHA could run the analysis now on a preliminary basis and provide everyone affected with a very good indicator of what savings may have been achieved for Year Two. If a corridor-type Charge per CMAD test were to be adopted, as I suggest below in this testimony, DHA might have to accumulate some additional charge information, but the information should be readily obtainable through Medicare cost reports, financial statements and other materials available to the DHA. The calculations would be very similar to those performed in the Expense per CMAD test.

Q. You mentioned earlier that you have a second suggestion for improvement of the methodology for determining the CMAD-related hospital savings. Would you please briefly describe it?

A. Yes. As I testified at the previous hearing regarding the determination of the aggregate measurable cost savings for the first assessment year, the computation of "casemix-adjusted discharges" (CMADs) forms the denominator of the Expense per CMAD amount, with expenses constituting the numerator. Therefore, anything that increases the denominator will have the effect of reducing the Expense per CMAD and any associated trend that is computed in the Expense per CMAD over time. The portion of the CMAD computation that relates to inpatient services is reasonably solid—it is the number of admissions (or discharges) multiplied by the hospital's all-payer casemix index. However, the outpatient component weights outpatient activity by comparing the average charge per outpatient visit to the average charge per inpatient case. The number of weighted outpatient visits is computed by multiplying the number of outpatient visits by the ratio of the average charge per outpatient visit to the average charge per inpatient case. Thus, the higher the outpatient charges, the higher the multiplier, and the higher the number of outpatient visits that will be counted in the denominator of the Expense per CMAD amount. Hospitals have substantial freedom to raise their outpatient charges. Increases in those charges do not necessarily reflect increases in the level of outpatient services that were provided. Accordingly, by raising their outpatient charges, hospitals can artificially increase the denominator of the Expense per CMAD amount and lower their Expense per CMAD. In this way, they can appear to be generating cost savings that are not real.

Q. Is this potential weakness important in the determination of ACMS?

A. Yes. In Maine, private insurers pay for almost all hospital outpatient services at a percentage of billed charges. In the scenario described above, a hospital could raise its outpatient charges, with the effect of increasing its number of CMADs and lowering its measured increase in Expense per CMAD, while the private insurers would be faced with

higher costs in terms of higher charge-based payments. The aggregate measurable cost savings would be inflated and, as a result, the private insurers would be assessed an inflated SOP while the higher charges would already have been reflected in health care payments and premiums.

Q. Wouldn't the "Consolidated Operating Margin" (COM) measure provide adequate protection against the possibility that hospitals would inflate their outpatient charges to artificially decrease their Expense per CMAD? Wouldn't higher outpatient charges raise their profits and hurt their ability to pass the COM test?

A. No. First, the DHA's consultant during the first year assessment, Dr. Nancy Kane, has written and lectured widely regarding the ability of hospitals to use various accounting policy adjustments to alter their consolidated operating margins to meet various objectives. Second, the COM and CMAD tests are separate—i.e., the DHA Board did not propose to count savings for only those hospitals that passed both tests. Therefore, a hospital that manipulated its outpatient charges to pass the CMAD test would be counted as having produced savings even if it flunked the COM test, or vice versa. Third, hospitals could, in theory, raise their outpatient charges by enough to allow them to pass the Dirigo CMAD test, and then offset these charge increases by increases in the discounts provided to the payers. The net result would be artificial savings counted in the Dirigo methodology with no associated real savings.

Q. How could the problem of possible manipulation of outpatient charges be fixed?

A. It could be fixed by freezing the ratio of outpatient charges per visit to inpatient charges per discharge at the latest pre-Dirigo level until a better measure of the quantity and complexity of outpatient services can be developed.

Q. Would it be feasible to develop such a measure of outpatient services?

A. Yes. The Medicare outpatient PPS uses "ambulatory payment categories" (APCs) and fee schedules to pay for outpatient services. The APCs have relative weights and weights could be developed for the fee schedule items on a basis consistent with the APC weights. This type of approach for the measurement of outpatient services would not be perfect but it would be far superior to the current CMAD approach of weighting outpatient services according to hospital charges.

Q. You stated earlier that you have three suggestions for improvements. What is the third suggestion?

A. My third suggestion is that the Expense per CMAD calculation could be changed to a Charge per CMAD approach. The use of charge data, rather than expense data, would be more relevant as a measure of savings because the private sector pays for hospital care primarily on the basis of charges rather than on the basis of expenses.

Q. Could the corridor approach that you are suggesting be applied on a Charge per CMAD basis rather than on an Expense per CMAD basis? What would be the advantages of a charge-based approach?

A. Yes, the corridor approach could be applied on a charges basis and there would be advantages to adopting this approach. Specifically, most private sector payments for hospital services in Maine are made on a percentage of charges (rather than on a cost) basis. Therefore, it is hospital charge increases, not expense increases, that drive medical care "costs" for self-insured accounts and premiums for insured accounts. The Expense per CMAD calculation that has been used by DHA, and which is discussed above, could be modified to substitute charges for expenses in the inpatient and outpatient calculations. The corridor would then be established in the same way as was described above, except

that the historical pattern of charge increases per CMAD, rather than expense increases per CMAD, would be compared to the HMBI trend line. The use of a Charge per CMAD test would also reduce the ability of the hospitals to artificially meet the CMAD test by raising their outpatient charges because those charge increases would affect both the numerator (i.e., charges) and the denominator (i.e., CMADs).

Q. Is it necessary or appropriate for the DHA to use both the CMAD and COM measures to measure Dirigo-related savings?

A. No, it is not necessary or appropriate. As discussed above, the COM measure is especially vulnerable to accounting decisions that can be used to adjust the COM to meet the objectives of the associated hospital or hospital system. The ability of hospitals to increase or decrease their COMs is not unlimited but it is significant enough to undermine the reliability of the COM for savings analysis purposes. In addition, as discussed above, a hospital can artificially reduce its Expense per CMAD by driving up its outpatient charges without necessarily raising its COM for the same time period. For the first SOP year, the DHA Board elected—despite the protestations of Anthem BCBS and other parties—to base its savings on the rate of growth in expenses rather than charges. As Anthem BCBS and others testified, private payers in Maine pay for most care on the basis of discounted charges, not on the basis of costs. However, within the framework of the DHA Board's cost-based savings measure, it is inappropriate to consider the profit margins of the hospitals, as well as their Expense per CMAD, in the determination of savings. The costs to the system are the actual costs, and the savings are the difference between those costs and the costs that would have occurred but for the operation of Dirigo Health. Whether the actual costs are associated with higher or lower real or reported profit margins is irrelevant. If the costs were $100,000,000, and they would have been $102,000,000 based on the Expense per CMAD test, the potential savings are $2,000,000—they are not $2 million plus or minus a COM adjustment. The COM test compares the level of net revenues to the level of expenses. If the COM test is also used, then the private payers are being asked to fund savings based on expense

reductions, measured by the CMAD test, even though they mostly pay according to charges, and they are also being asked to fund savings based on a COM test that is technically unsound, for the reasons described above, and potentially duplicative because it reflects the expense experience that was already counted under the CMAD test. The use of the COM test is technically flawed, and conceptually muddled, and it should be dropped from the savings determination.

It appears from the Mercer Report that DHA will not be proposing the use of a COM test for the second year assessment. For the reasons stated above, I believe this is an improvement to the overall methodology.

Q. How about savings that are supposed to come from reduced levels of bad debt and charity expenses that result from expansions in Medicaid eligibility and/or increases in the Dirigo health plan enrollment? Should they be separately computed in measuring savings?

A. No. It seeems to me that including the bad debt and charity care changes as a separate cost savings component represents a double counting of savings. The CMAD measure is based on alleged reductions in expenses and the assertion that lower expenses produce savings for private carriers even though those carriers pay on the basis of charges. The fact that the private carriers pay on the basis of charges is treated as irrelevant by the DHA when it computes the CMAD-related savings. However, for the bad debt and charity measure, the DHA argues that it is not lower expenses that matter, and argues that it is lower charges, driven by better Medicaid coverage, that matter in counting savings.

In my view, the conceptualization of the CMAD and bad debt/charity care items as items that are separate and additive in the determination of savings reflects a high level of confusion in the formulation of Dirigo savings estimates. An increase in Medicaid funding (or other funding) that reduces bad debt and charity amounts does not reduce hospital expenses. The patients who received these services in the past generated

expenses and they will continue to generate expenses in the future. The level of expenses does not change unless the clinical requirements of these patients change. I do not believe that DHA has quantified any savings that might be attributed to the earlier treatment of such patients that might occur if they were covered by health insurance. Therefore, the only effect of improved funding is that the expenses associated with patients who might formerly have been bad debt or charity patients will be covered by different revenue sources than in the past—namely, they will be covered by Medicaid, or by the Dirigo health plan, whereas they were covered in the past by higher private sector payments from insurers like Anthem BCBS, or from uninsured but financially capable patients who paid charges, or from other hospital resources such as gifts and bequests earmarked for these purposes. All other things being equal, an increase in health insurance coverage (through expansion of Medicaid eligibility, the Dirigo Health plan, or other sources) would not reduce expenses, other than perhaps in the relatively minor area of collection expenses, but it would enable hospitals to reduce the level of charges they would otherwise need to set to meet their financial requirements. In order to properly capture these savings, the expense-based CMAD measure should be replaced with a charge-based CMAD measure.

Q. Are you saying that a charge-based CMAD measure would be superior to the expense-based measure? And that it would obviate the need for a separate bad debt and charity measure?

A. Yes. The SOP is to be applied to the private carriers and administrators. These entities primarily pay hospitals on a charge-related basis. Even where they pay on a per diem, DRG or other fee schedule basis, their payments are not based on expenses. As discussed above, hospital expenses are only one factor—along with changes in payer mix, outside funding sources, profit requirements, etc.—that drive hospital charges. Thus, a decrease in hospital expenses does not usually result in a corresponding proportional decrease in charges. The change in charges may be equal to, more than or less than the expense change because of the interplay of the various factors that drive charge levels.

The change in expenses will have no impact on "fixed" rates, such as per diem or DRG-based payment rates, especially when those rates are established in multi-year contracts that are not linked to expense changes. Thus, when savings are equated to changes in the expense per CMAD, the linkage is conceptually flawed because the private sector does not pay on the basis of expenses and does not necessarily benefit from any expense savings that occur, unless those expense savings are reflected in reductions in hospital charges. This error is further compounded by the fact that the DHA Board counts its savings across all payers, despite the fact that Medicare and Medicaid account for more than half of all hospital utilization in Maine and the state has no mechanism for collecting the related portion of the SOP from the federal government.

These fundamental problems could be addressed by adopting a charge-based SOP savings calculation; by applying to it the corridor approach I described above; and by computing the SOP payment based on the private sector share of any identified system-wide savings.

Q. What data would you need to establish the "corridor" analysis described above for the second assesement year whether it was based on expenses or charges?

A. I outlined above the data that would be needed for a corridor-type Expense per CMAD. If a corridor-type Charge per CMAD test were to be adopted, DHA might have to accumulate some additional charge information, but the calculations would be very similar to those performed in the Expense per CMAD test and would not require a large amount of additional work.

Q. Have you reviewed the document entitled "Dirigo Health Savings Offset Payment: Year 2—Methodology and Data Sources" that was prepared by Mercer for the DHA? If yes, what comments do you have regarding it?

A. I have very briefly reviewed the specified document and proposed methodology as it only became available in the late afternoon of March 20. I have a few very preliminary comments because they have not presented any of the relevant data nor have they specified their calculations or conclusions.

Q. What are those comments?

A. First, it appears that the DHA has abandoned their previous approach to the CMAD calculation of discarding higher than expected cost increases while counting all lower than expected cost observations. I reserve my right to examine their calculations when they become available, but if they apply the methodology as suggested in the Mercer Report, the new "aggregate" approach—in which they basically construct a "composite" statewide Expense per CMAD and examine actual versus expected changes in it—would seem to be an improvement over the methodology that the DHA Board proposed to the Superintendent last year. That said, the composite approach would give equal credibility to all observations, including those that occur within the established historical range of cost experience. I believe that the corridor approach could be applied to the "composite" CMAD approach (by looking at the historical range of fluctuations in the composite CMAD, relative to the HMBI, in the pre-Dirigo years) and counting savings only if the change in the expense per CMAD is lower than expected by an amount that exceeds the historical range. I believe that the addition of this corridor feature would produce a savings methodology that would be much more reliable and credible than a pure composite approach which, while an improvement over the DHA Board methodology posed in year one, would continue to count as "savings" expense levels that are within historical expectations.

Second, the Mercer Report asserts, on page 3, that "Reducing the rate of increase in the cost of services reduces the need for payer rate increases and results in savings to the entire health care system." As I have stated above, this connection is very quixotic. Hospitals may or may not choose to pass on cost savings to payers in the form of lower charges in any given year. To the extent reductions in the cost of services do not reduce

payer rate increases, the proposed methodology remains flawed if the goal is to calculate savings in such a way that the resulting SOP amount does not represent an added cost to private payers, with no corresponding savings offset. As I explained earlier, moving to a charge-based approach would remove this fundamental flaw.

Third, I am concerned with Mercer's statements that "Mercer is not an expert in Medicare Cost Reports (MCRs)"... and "Mercer relied on the work done by Dr. Nancy Kane" in formulating the Year Two methodology. (Mercer Report, p.2) As the Year One hearings showed, the Medicare Cost Reports are at the core of the CMAD savings methodology and the data drawn from them and the calculations that were based on them were the subject of considerable debate at the hearing. It is, therefore, troubling to me that Mercer, with its acknowledged lack of expertise in these issues, will be simply relying on the prior work by Dr. Kane, without having access to her knowledge and expertise and without presenting Dr. Kane as a witness who may be examined at hearing on the underlying methodology and the implications of the new approach suggested by Mercer for the calculation of CMAD savings.

Finally, Mercer cites as one of its "Guiding Principles" on page 8 of the Year Two savings document the unassailable maxim that the Dirigo savings "should not be overstated, nor should they be understated." This principle also applied last year, but Mercer nevertheless submitted a savings estimate of $233 million that was eventually whittled down by 75% to $43.7 million in the Superintendent's decision. The composite approach is an improvement over last year's DHA Board approach, but it is certainly not "conservative" in nature—it will count any savings that are measured as Dirigo savings even though there are many factors other than Dirigo that drive cost savings when they occur. I believe that Mercer's statement, on page 14 of the Mercer Report, that the "adjudicatory hearing clearly established that Dirigo was the primary driver of positive cost savings" in the system is not accurate. I attended the hearings and I believe that just the opposite conclusion was driven home—specifically, that hospital expenses fluctuate every year and that it is extremely hard to isolate the influence of one factor, such as Dirigo, in the midst of many factors that influence cost trends.

Q. As you know, the DHA has taken the position that it cannot go forward now and present its aggregate measurable cost savings calculations and has moved to continue the hearing in this matter until August to await certain cost report information. Do you believe that the Mercer Report supports DHA's request to delay?

A. No, I believe the opposite is true. Mercer makes clear that the methodologies for the various savings measures that it believes are appropriate may be established now. (*See* Mercer Report, p.1: "the methodologies for calculation can be established.") The only question then, is whether we need to wait for 100% of the cost report data to go forward. I believe the answer to that question is most clearly "no". Most of the data are currently available and, quite frankly, I believe that we should be focused on establishing an appropriate methodology rather than on finding out what result it will produce.

I believe that the cost report data is available in the CMS "HCRIS" files, which are publically available, for all but the eight Maine hospitals that have fiscal years ending December 31. The largest hospitals in Maine have fiscal years ending on dates earlier than December 31. Therefore, approximately 85% of the cost information necessary to perform the CMAD calculations for 2005 is already available. It is my understanding that the Maine Health Data Organization receives hospital discharge data within ninety (90) days after the end of each quarter, which means that they should already have these data for all except the hospitals whose most recent fiscal year end was December 31, 2005. The spreadsheets that were developed during the first year assessment proceeding already contain all of the historical data necessary for the composite CMAD methodology that Mercer has proposed and, as indicated, upwards of 85% of the new data neeeded for this year's calculation is already available. These new data will need to be entered into the spreadsheets eventually, and I see no reason why they should not be entered now so that we may move forward with an examination of the methodology. As I observed earlier, we should be primarily concerned with the legitimacy of the methodology, rather than with its results, and we certainly should not be delaying the hearing to obtain the

final 15% or so of the results. We can, and should, go forward now so that the process can move along as contemplated in the Dirigo Legislation.

Q. Does this conclude your pre-filed testimony?

A. Yes.

Certificate of Service

I, Christopher T. Roach, Esq. certify that the foregoing Prefiled Testimony of Jack Keane was served this day upon the following parties via U.S. and Electronic Mail.

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Dated: March 22, 2006

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Exhibit 3

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March 22, 2006

VIA HAND DELIVERY
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In Re: Determination of Aggregate Measurable Cost Savings
For The Second Assessment Year (2007)

FILING COVERSHEET

Dear Ms. Theberge:

Enclosed for filing please find the following:

SUBMITTED BY:	Christopher T. Roach
DATE:	March 22, 2006
DOCUMENT TITLE:	Non-Confidential Version of Prefiled Testimony of William Whitmore
DOCUMENT TYPE:	Prefiled Testimony
CONFIDENTIAL:	**NO**

Thank you for your assistance in this matter.

Very truly yours,

Christopher T. Roach

cc: William Laubenstein, Esquire
William Stiles, Esquire
Bruce Gerrity, Esquire
D. Michael Frink, Esquire
Joseph P. Ditre, Esquire
Kelly Turner, Esquire
James Smith, Esquire

NON-CONFIDENTIAL

STATE OF MAINE
DIRIGO HEALTH AGENCY

IN RE:	)	EXHIBIT 3
	)	
DETERMINATION OF AGGREGATE	)	
MEASURABLE COST SAVINGS FOR	)	PREFILED TESTIMONY OF
THE SECOND ASSESSMENT YEAR	)	WILLIAM WHITMORE
(2007)	)	
	)	
Docket No.	)	
	)	March 22, 2006
	)	

NON-CONFIDENTIAL

Q. Please state your name and your position with Anthem Health Plans of Maine, Inc., d/b/a Anthem Blue Cross and Blue Shield ("Anthem BCBS").

A. My name is William Whitmore. I am an Actuary with Anthem BCBS in its Maine office.

Q. Please describe any relevant experience that qualifies you as a witness in this proceeding.

A. I have been employed by Anthem BCBS since 1989 with the exception of one year of that time in 2000 spent working for an actuarial consulting firm. During my time with Anthem BCBS I have worked in many aspects including individual pricing, small group pricing, large group pricing, trend analysis, and valuation. During 2004 I was responsible for pricing the product now known as DirigoChoice. I also participated in the first year assessment hearings before the Bureau of Insurance by preparing prefiled testimony and testifying at the hearing on the Bureau's review of the savings calculation and methodology proposed by the Dirigo Board.

Q. What is the purpose of your testimony?

A. There are two primary purposes to my testimony today: (1) to explain how premium rates are calculated and the necessarily inherent implications of any Dirigo Health generated savings on those premium rates for our members; and (2) to provide an opinion of an alternative methodology that in my view more fairly calculates the aggregate measurable savings as a result of the operation of Dirigo Health.

Q. Before we go further, are you testifying here about whether the Dirigo legislation allows CMAD savings to be included in the determination of aggregate measurable cost savings?

A. No, the question of what types of calculated "savings" are within the ambit of the calculation of aggregate measurable cost savings within the Dirigo legislation is a legal determination that I am not qualified to make. I also understand that those very issues are on appeal and, depending on the outcome, the calculation of aggregate measurable savings could change dramatically. I was asked only to review the CMAD methodology within the Superintendent's Decision and Order from last year, and comment on whether that methodology could be improved, irrespective of whether cost savings resulting from the calculation should, or should not, be included as savings that result from the operation of Dirigo Health under the Dirigo legislation.

Q. With that understanding, why do you feel it is important to explain how Anthem BCBS calculates premium rates?

A. Because there were, and I fear there remain, misconceptions about the way "savings" – whether as a result of the operation of Dirigo Health or not – flow to Anthem BCBS and then on to the its subscribers, the healthcare consumers of Maine. Those misconceptions resulted in some suggesting that insurers, like Anthem BCBS, retained the "savings" from Dirigo Health and then refused to return those savings to consumers by passing through the savings offset payment, rather than absorbing this additional cost. It is unclear how widespread this fundamental misconception is, but the issues surrounding Dirigo Health are important to the State, its residents, and Anthem BCBS's members and it is critical that all understand the basics of rate-setting so that all can maintain focus on the relevant issue: the amount of the aggregate measurable savings as a result of the operation of Dirigo Health that fall within the parameters of the Act.

Q. What happens to actual cost savings that result from the operation of Dirigo Health?

A. Those savings are included in the calculation of the premium rates that our members pay.

Q. How do the savings pass through to your members?

A. To answer that, I need to start with a description of our provider network and how we contract with providers in that network.

Anthem BCBS has a very broad network of providers from which our members can choose to receive services. To ensure network stability, Anthem BCBS has contracts with those providers that define the nature of the contractual relationship as well as the rates at which Anthem BCBS will pay the providers for the services they render to Anthem BCBS's members. As such, it is in Anthem BCBS's best interest, and in the best interest of our members, to secure from providers contract rates that are as low as possible, while maintaining a broad network in compliance with Maine law.

Anthem BCBS's provider contracting area negotiates with hospitals and other providers to ensure that Anthem BCBS is getting the best possible rates for the services that the hospitals provide to our members. The rate that the hospital is willing to negotiate to is made up of many factors, one of which is the cost of the services the provider performs. If there are reductions in the provider's costs in any particular year, if all else is equal and the provider is willing and able to pass those cost reductions on in the form of a lower contract rate, Anthem BCBS's costs for that particular service will also be reduced.

Q. That explains how Anthem BCBS's costs would be reduced, but how do those provider cost reductions end up reducing premium rates?

A. Premium rates charged to all members for a given period are calculated by Anthem BCBS's actuaries and underwriters based on projected claims (*i.e.*, the amount that Anthem BCBS expects to pay healthcare providers for the applicable period for the services providers perform for Anthem BCBS members). The total

of all provider contracts, including any reductions in provider contract rates, are used to develop those claim projections. This means that any impact from the operation of Dirigo Health that truly reduces healthcare provider charges would be reflected in Anthem BCBS's claim projections and, accordingly, the premium rates that our members pay for insurance.

Q. Will the cost savings flow to all of Anthem BCBS's customers, including self insured large groups, fully insured large groups, small groups, and individuals?

A. Yes, it will. In fact, despite the perceived differences in these types of risk, the rating process is nearly identical. I believe that a more detailed explanation here will be useful in understanding how the savings are passed on.

First, let me begin with the example of a self insured group. Self insured groups, or administrative services only ("ASO") groups, contract with Anthem BCBS to administer their health plan, but not underwrite the risk of the claims. This means that Anthem BCBS provides all adminstrative services, including paying claims for the ASO group, but is later reimbursed for the claims. Accordingly, Anthem BCBS has no risk for the group's actual claim experience, and the product is priced to reflect that.

In the typical ASO arrangement, Anthem BCBS will project an estimate of the ASO group's future claims for the group's budgeting purposes. This projection is based on using the group's own paid claim experience and applying an estimate of future claim trends based on Anthem BCBS's estimate of future healthcare cost and utilization changes.

Q. So, in essence, Anthem BCBS works as an intermediary for the self insured group by paying providers for the the group's claims and the group reimburses Anthem BCBS dollar for dollar for those claims?

A. Yes, that is correct. In this arrangement Anthem BCBS is selling only its services to the group. One of these services is the negotiated discounts that Anthem BCBS receives from providers. The group benefits directly from Anthem BCBS's ability to negotiate lower fees with providers. If these negotiated amounts are lower due to the operation of Dirigo Health, then the group benefits directly.

Q. In this type of arrangement, where Anthem BCBS pays claims and is then reimbursed, how could Anthem BCBS retain any discounts, or savings, from providers?

A. It would be impossible for Anthem to keep any discounts or savings that come through as part of the payments to providers because the actual claim costs ultimately are paid by the group, not by Anthem BCBS.

Q. That explains the self insured large groups. What happens with fully insured large groups?

A. The process is nearly identical. For large fully insured groups, Anthem BCBS will project an estimate of the group's future claims in order to set the claim portion of the group's total premium. As with self insured groups, this projection is based on using the group's own actual paid claim experience and applying an estimate of future claim trends based on Anthem BCBS's estimate of future healthcare cost and utilization changes. The only difference from a self insured group is that Anthem BCBS is at risk for the claim payment to be made from the premium received from the group.

Q. How can this rating process work for a small group? How could a group of three people, for instance, have enough claims to be considered reliable as the basis for predicting future claims?

A. It is quite possible for a group of three people to have no claims during any given year. Therefore it is not possible to use a small group's claim experience as a basis for predicting future claims.

Q. But you noted earlier that the premium for a small group is derived in the same way that the premium for a large group is derived?

A. It is, but not for each and every small group standing alone. In Maine it is required that the small group market, defined as groups with fifty or fewer employees, be rated on a "community" basis. What this means is that all small groups are combined together in order to create one large community, or "group of groups". The size of the community makes it possible to use the claims for the entire community as a predictor of future claims. Anthem BCBS will project an estimate of the community's future claims in order to set the claim portion of the small group community's total premium. As with all large groups, this projection is based on using the community's own paid claim experience and applying an estimate of future claim trends based on Anthem BCBS's estimate of future healthcare cost and utilization changes.

Q. That leaves individuals who purchase their own health insurance because they do not have insurance through an employer. How is the premium determined for an individual?

A. It is the same as with small group, except rather than aggregating all small groups in one community for rating purposes, all individuals are combined together in order to create one large group of individuals. Again, the size of the group of individuals makes it possible to use the claims for the entire group as a predictor of future claims. Anthem BCBS will project an estimate of the group of individual's future claims in order to set the claim portion of the individual total premium. As with all large and small groups, this projection is based on using the group of individual's own paid claim experience and applying an estimate of future claim trends based on Anthem BCBS's estimate of future healthcare cost and utilization changes.

Q. In each of the examples (large group self insured, large group fully insured, small group, and individual) that you have described above you have noted that the actual paid claims to providers are used as the basis for predicting future claims and thus the basis for premiums charged by Anthem BCBS. How then would it be possible for Anthem BCBS to retain cost savings in premiums, whether or not those cost savings are as a result of the operation of Dirigo Health?

A. It is not possible for Anthem BCBS to retain any such savings, but as explained below, even if it were theoretically possible, Anthem BCBS is regulated by the Maine Bureau of Insurance and, accordingly, the Company's financial records are regularly scrutinized by the Bureau and its calculation of premium rate components, including claims trends, are scrutinized annually in all individual rate filings.

We start with the explanation provided above: premium rates are determined based on the actual and projected costs of providing the healthcare to insured members. Putting to one side the annual scrutiny by the Bureau, in order for Anthem BCBS somehow to retain cost savings and avoid passing them through to the benefit of members, when calculating rates, Anthem BCBS would have to

artificially add the cost savings back on to claims that were actually paid to providers. Beyond this, in order to avoid detection, all insurers in the market, as well as ASO groups that pay their own claims, would have to agree to inflate actual provider costs at aproximately the same margin. The idea that there exists an industry-wide agreement among insurers and ASO group employers to defraud insured members and employees out of cost savings from the operation of Dirigo Health is unfounded and would not pass the scrutiny of the Bureau, Anthem BCBS's subscriber groups or the multiple internal and external audits that the Company routinely undergoes.

Even if such a multi-layered agreement among market participants were otherwise conceivable (which it is not), Anthem BCBS is regulated by the Maine Bureau of Insurance – the same Bureau of Insurance that reviews the DHA Board's recommended calculation of the aggregate measurable cost savings as a result of the operation of Dirigo Health. As part of the regulatory process, the Bureau of Insurance regularly reviews Anthem BCBS's finances and, whenever Anthem BCBS seeks a rate modification for its individual products (*e.g.*, HealthChoice), the Bureau of Insurance examines every component of the proposed premium rates, including the projected claim trends and profit margins, to ensure that they are reasonable. The Superintendent most recently examined these components in the late Fall of 2005 – after the Superintendent issued his Decision and Order on the First Year Determination of Aggregate Measurable Savings – finding that all savings as a result of the operation of Dirigo Health were already reflected in the premium rates Anthem BCBS proposed in that proceeding. *See, e.g.*, Docket No. INS-05-820, *In re Anthem Blue Cross and Blue Shield 2006 Individual Rate Filing for HealthChoice and HealthChoice Standard and Basic Products*, Decision and Order issued December 19, 2005, p.10 ("[Mr. McCormack] testified that he was confident that the current contracts with healthcare providers were the best contracts that Anthem could secure and that embedded in those contract rates were the savings attributable to Dirigo. Furthermore, Mr. Whitmore [Anthem BCBS's actuary] testified these savings attributable to Dirigo had been incorported into the filed rates. The Superintendent concludes that Anthem has

made best efforts to ensure recovery of the savings offset payment through negotiated reimbursement rates with health care providers that reflect the health care providers' savings as a result of Dirigo health care initiatives.")

Q. Has Anthem BCBS followed this same premium development process that you have described since the effective date of the Dirigo legislation?

A. Yes. The process has remained the same both before and after the effective date of the Dirigo legislation. Anthem BCBS still attempts to negotiate the lowest possible rate with each provider. The only difference is that we now request each hospital's bad debt and charity care costs and probe each hospital specifically to ensure that the negotiated rate includes any cost savings as a result of the operation of Dirigo Health.

Q. If the cost savings attributable to the operation of Dirigo Health are included in the calculation of premium rates, would it make sense to prohibit insurance carriers and third party administrators from including the savings offset payment in premium rates?

A. No, that would not be fair or logical because it would amount to double-dipping on the cost savings. The funding mechanism for Dirigo Health is cumbersome and convoluted and, as a result, is currently under review by key stakeholders. In theory, however, the math is relatively straightforward: every dollar of cost savings that flow from the healthcare provider to the insurance carrier results in a one dollar reduction in premium rates. That same dollar is included as part of the savings offset payment initially paid by the carrier or third party administrator, and is thereafter added to the premium rates paid by those with private insurance, including Anthem BCBS's members. In this way, there is no cost impact on the insured member: $1 of savings reduces the member premium by $1; the SOP of $1 is added to premium rates as an "offset" to the "savings" that reduced the premium rate in the first place. If the methodology for

calculating the SOP is sound, the resulting impact on members is $0 (*i.e.*, Starting Premium Rate – ($1 in cost savings) + ($1 in SOP) = Starting Premium Rate). This circular funding is, arguably, the very foundation of the theory behind Dirigo Health.

Q. Does the Dirigo Act itself contemplate that insurance carriers and third-party administrators should absorb the savings offset payments?

A. No. To the contrary, the Dirigo Health Act logically provides for inclusion of the savings offset payments in the form of an increase to paid claims associated with the premiums of fully insured business and to claims paid on behalf of self-insured employers:

> The savings offset payment, as determined by the [Dirigo] board . . . is the determining factor for inclusion of savings offset payments in premiums through rate setting review by the bureau.

24-A M.R.S.A. § 6913(2).

Indeed, if it were otherwise, the Dirigo Act would run headlong into the long-standing and well-established law that premium rates must be adequate to cover all costs, plus allow for a reasonable rate of return. The Superintendent is prohibited from approving rates that are inadequate, yet that would be precisely the result if administrators and carriers, like Anthem BCBS, were required to pass through cost savings to reduce premiums, but at the same time prevented from included the SOP amount in rates.

Q. Have you reveiwed the methodology that has been proposed by DHA for the Second Assessment Year?

A. The Procedural Order for this proceeding required all of the parties to designate witnesses, provide summaries of their testimonies, and exchange documents on or before March 10, 2006. That same Order required the identification of proposed alternative methodolog[ies] for calculation of aggregate measurable cost savings on or before March 13. As such, it was implicit in the schedule that the DHA would provide sufficient details of its proposed methodologies in its witness summaries; otherwise, requiring the other parties to

identify alternatives to the DHA's methodology by the following Monday would make no sense. All of the intervenors, except Consumers for Affordable HealthCare, complied with all of these deadlines, including identification of potential alternative methodologies. Notwithstanding these requirements imposed by the DHA Board, the DHA itself failed to comply with the deadlines and was finally ordered by the Presiding Officer to identify its methodology by March 20, the original deadline ordered by the DHA Board for filing of prefiled testimony in this proceeding. The DHA did make this late filing on March 20 and provided a report from its consultant, Mercer Government Human Services Consulting ("Mercer"), summarizing the methodologies that Mercer proposes should be used for calculation of aggregate measurable cost savings in the second assessment year (the "Mercer Report"). Citing incomplete data, Mercer suggests that it would be "impossible" to perform the calculations under the methodology it proposes. Although the Mercer Report reflects that the vast majority of the data applicable to Mercer's proposed methodologies is "currently available", DHA provided no data or documentation in support of the proposed methodologies.

The point of my recitation of these facts is to make clear that I have had access to the DHA's summary identification of its methodology for less than 48 hours before my own testimony had to be finalized so that it could be prepared for filing. As such, while I have read the DHA's summary identification of its methodology, I have had almost no time to give it more than a cursory review and had no access to any of the data that DHA has in its possession that supports its methodology and calculation. Depending on the type of data provided and the timeframe in which it is provided, it is unclear whether I will have a meaningful opportunity to review that data before the hearing. I also obviously have not reviewed the DHA's testimony in support of the methodology as it was not available to me at the time my testimony was prepared.

Q. Understanding that you have had only very limited time to review the DHA summary, do you have a sense of the methodology that DHA proposes for the second assessment year?

A. Yes, it appears that the DHA will rely heavily on the Superintendent's Decision and Order from the first assessment year. As such, although we have not yet had an opportunity to examine DHA's proposed methodology in any level of detail, I can provide my preliminary perspective under the assumption that the DHA's methodology will track the Superintendent's Decision from the first assessment year. I will almost certainly have follow-up testimony to offer at the hearing once I have an opportunity to review DHA's proposal in more detail.

Q. You testified in the last proceeding that the Dirigo Board's cost per case mix adjusted discharge ("CMAD") methodology suffered from several significant flaws. Has your opinion of that methodology changed?

A. No. The Dirigo Board methodology was significantly flawed in that it counted only those costs that were below the line and ignored "dissavings"; it failed to take account of natural fluctuations in hospital expenses; it was easily manipulated; and there was no objective, or subjective, verification of any kind to determine whether the "cost savings" calculated by that measure were actually as a result of the operation of Dirigo Health. The fact that one could use the Board's methodology in other time periods in Maine when Dirigo did not exist, or in any other state, and still produce a numerical "savings" illustrated the illegitimacy and inaccuracy of the Board's methodology. Additionally, the Board's CMAD is a hospital expense based measure and is not based on actual charges to carriers for services provided to their members. While it is reasonable to believe that there is a correlation between a hospital's expenses and its charges to patients and insurers, it is also reasonable to believe that this relationship can vary from year to year based on a hospital's varying financial condition, as well as other factors unrelated to the impact from the operation of Dirigo Health.

Q. Did the modification by the Superintendent in which he "netted" all hospital results when calculating the cost per CMAD fix the problem with the Board's methodology?

A. The Superintendent's modification was certainly an improvement in the methodology, but it did not fix entirely the Board's flaw in counting as "savings" those cost results that were actually predicted in the absence of Dirigo Health.

Q. Has Anthem BCBS developed an alternative methodology for calculating cost savings that is more consistent with the Dirigo Act?

A. As I previously stated, I have no opinion on what particular savings are within the language of the Dirigo Act because that is a legal interpretation. Within that context, however, the answer to your question is, yes, Anthem BCBS has developed an alternative Expense per CMAD calculation that is more accurate than the CMAD methodology approved by the Superintendent last year. Mr. Keane provides the details of the methodology in his testimony.

Q. Do you believe that Mr. Keane's alternative methodology for calculating cost savings is a better methodology than the one put forward by the Dirigo Board?

A. Yes, I believe that Mr. Keane's alternative methodology for measuring savings is superior to that put forth by the Dirigo Board.

Q. Please explain why you believe so.

A. The alternative methodology set forth in Mr. Keane's testimony addresses one of the primary failings of the Dirigo Board's cost per case mix adjusted discharge

("CMAD") calculation in that it accounts for expected random fluctuations in this measurement and does not simply attribute these natural fluctuations to Dirigo Health and label them as savings. Mr. Keane's methodology sets up corridors, or ranges, of expected variance in the expense per CMAD for each hospital so that, unlike the Dirigo Board's methodology, expected results are not counted as "cost savings." We also noted significant anomalies in last year's results using the Dirigo Board methodology and that there was no effort to investigate those anomalous results to determine the cause; instead, the results were simply counted as savings. Mr. Keane suggests, and I agree, that there ought to be some level of follow-up investigation with the hospitals that experience unexpectedly low rates of cost growth to attempt to discern the cause(s) of those unexpected results. Without taking this second step, it is not possible to verify, with any degree of reasonable certainty, the cost savings that are actually as a result of the operation of Dirigo Health, as the legislation directs.

Q. Will Mr. Keane's alternative methodology be an improvement to the methodology used by the Board?

A. Yes, it will. First, it removes the attribution of naturally occurring random fluctuations in the CMAD to Dirigo savings. Hospitals identified as having fluctuations outside of the expected range will be reviewed in an attempt to verify if the fluctuation is due to Dirigo Health. Provider contracts will be reviewed and providers will be contacted in an attempt to accurately attribute savings to Dirigo Health and not to other factors which might influence a hospital's expenses. For the reasons stated in his testimony, I also agree with Mr. Keane's proposal that a charge-based methodology would produce a more accurate result.

Q. Does this conclude your testimony?

A. Yes.

CERTIFICATE OF SERVICE

I, Christopher T. Roach, Esq. certify that the foregoing Prefiled Testimony of William Whitmore was served this day upon the following parties via U.S. and Electronic Mail.

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Dirigo Health Agency Attn: James Smith, Esquire—Hearing Officer 53 State House Station Augusta, Maine 04333-0053	William Stiles, Esquire Verrill Dana LLP One Portland Square P.O. Box 586 Portland, ME 04112-0586
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Dated: March 22, 2006

Christopher T. Roach, Esq.

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Exhibit 4

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March 22, 2006

VIA HAND DELIVERY
Board of Directors
Attn: Lynn Theberge
Dirigo Health Agency
53 State House Station
Augusta, Maine 04333-0053

In Re: Determination of Aggregate Measurable Cost Savings
For The Second Assessment Year (2007)

FILING COVERSHEET

Dear Ms. Theberge:

Enclosed for filing please find the following:

SUBMITTED BY:	Christopher T. Roach
DATE:	March 22, 2006
DOCUMENT TITLE:	Non-Confidential Version of Prefiled Testimony of Thomas Drottar
DOCUMENT TYPE:	Prefiled Testimony
CONFIDENTIAL:	**NO**

Thank you for your assistance in this matter.

Very truly yours,

Christopher T. Roach

cc: William Laubenstein, Esquire
William Stiles, Esquire
Bruce Gerrity, Esquire
D. Michael Frink, Esquire
Joseph P. Ditre, Esquire
Kelly Turner, Esquire
James Smith, Esquire

NON-CONFIDENTIAL

STATE OF MAINE
DIRIGO HEALTH AGENCY

IN RE:	)	EXHIBIT 4
	)	
DETERMINATION OF AGGREGATE	)	
MEASURABLE COST SAVINGS FOR	)	PREFILED TESTIMONY OF
THE SECOND ASSESSMENT YEAR	)	THOMAS DROTTAR
(2007)	)	
	)	
Docket No.	)	
	)	March 22, 2006
	)	

NON-CONFIDENTIAL

Q. Please state your name and your position with Anthem Health Plans of Maine, Inc., d/b/a Anthem Blue Cross and Blue Shield ("Anthem BCBS").

A. My name is Tom Drottar and I am a Provider Network Manager.

Q. Please describe any relevant experience that qualifies you as a witness in this proceeding.

I have held this position for approximately five years. During this time I have been extensively involved in negotiating hospital, physician hospital organization (PHO) and physician group contracts. I have participated in negotiations with most of the hospitals in the state and also many physician groups, both before and after the effective date of the Dirigo legislation.

Q. What is the purpose of your testimony?

A. The purpose of my testimony is to explain the mechanics of hospital and physician contracting in Maine, how our process at Anthem BCBS has changed since the implementation of the Dirigo legislation, the extent to which we investigate whether our network of providers have experienced savings that result from the operation of Dirigo Health, and my view that the alternative methodology outlined in Mr. Keane's testimony is far superior to the hospital related methodologies proposed by the Dirigo Board in the first assessment year.

Q. Please explain the mechanics of hospital contracting.

A. Anthem BCBS's provider contracting area negotiates with hospitals and other providers to ensure that Anthem BCBS is getting the best possible rates for the services that the hospitals provide to our members. The rate that the hospital is willing to negotiate to is made up of many factors, one of which is the cost of the services the provider performs. If there are reductions in the provider's costs in any particular year, if

all else is equal and the provider is willing and able to pass those cost reductions on in the form of a lower contract rate, Anthem BCBS's costs for that particular provider will also be reduced.

Provider Network Management has the same goal with respect to contracts today as we did before the Dirigo legislation passed. That goal is to secure the best possible rates for our members in each negotiation. In addition to working for the best possible rates, our negotiation protocol now includes a requirement that hospitals and physician groups identify to us in writing the applicable group's bad debt and charity care costs, the extent of any savings as a result of the operation of Dirigo Health, and whether or not the hospital or provider group is passing on the full extent of those savings in the group's contract rates.

Q. Did the Superintendent find that Anthem BCBS used best efforts to recover savings in the first assessment year?

A. Yes. The Superintendent most recently examined this question in the late Fall of 2005, finding that Anthem BCBS used best efforts to recover the savings and that all savings attributable to Dirigo were embedded in the premium rates Anthem BCBS proposed in that proceeding. Accordingly, the Superintendent authorized Anthem BCBS to include the full savings offset payment amount in member rates. *See, e.g.*, Docket No. INS-05-820, *In re Anthem Blue Cross and Blue Shield 2006 Individual Rate Filing for HealthChoice and HealthChoice Standard and Basic Products*, Decision and Order issued December 19, 2005, p.10 ("[Mr. McCormack] testified that he was confident that the current contracts with healthcare providers were the best contracts that Anthem could secure and that embedded in those contract rates were the savings attributable to Dirigo.").

Q. Has there been any change in the second measuring period?

A. No. There has been no change in the contracting philosophy or practice in the second measuring period. Our team of negotiators continues to use best efforts to recover in contracted rates any cost savings as a result of the operation of Dirigo Health.

Q. Please explain how hospital payment mechanisms work

A. Discount from charge is the most prevalent methodology of payment. This payment mechanism involves the provider billing a dollar charge for a particular service on a claim. If the service is a covered service under the member's certificate of coverage, and the service was authorized as medically necessary, the claims system applies the negotiated discount from charge to the claim. The resulting amount is the "allowed" amount, which reflects the total amount the hospital expects to recoup for the service through payments by Anthem BCBS and/or the member through cost shares. The other primary arrangement is fixed pricing. Under this methodology, Anthem BCBS pays a fixed price for a service or bundle of services provided to our members. The fixed price, except for some outlier provisions, which are used to compensate the hospitals for unusually costly cases, is the "allowed" price regardless of the charge.

Q. Does cost shifting influence the difference between a hospital's cost increases and their charge increases?

A. Yes. Cost shifting is one of the leading drivers for rate increases that is raised when we negotiate with hospitals and physicians. While MaineCare enrollment has increased in recent years, the overall number of uninsured Mainers has remained relatively constant. This is because the number of people covered by commercial insurance has declined. For hospitals, it is reasonable to infer that even though the number of uninsured has not changed, their net payments have been reduced by tradeoff from higher commercial payments rates to lower MaineCare reimbursement. Anecdotally, hospitals have informed me that increases in MaineCare enrollment do not necessarily result in a reduction in bad debt and charity costs. This adds additional

pressure on the remaining commerically insured population as hospitals must cost shift more to offset the reduction in net payments.

I believe that many providers do not consider there to be net savings attributable to Dirigo until they have been made whole for other changes in their government reimbursement and changes in bad debt and charity care. So long as prior payments and settlements are due hospitals and government reimbursement levels do not keep up with cost increases, providers likely will be unwilling to pass on to insurers any "savings" attributable to Dirigo.

Q. Are all hospital payments made by private payors, like private insurance companies?

A. No. There is a substantial portion of revenue at Maine hopsitals that is derived from governmental payors. At many rural hospitals, this amount may exceed 70% of total revenue.

Q. If a large percentage of hospital revenues are derived from governmental – as opposed to private payor – sources, does that fact have implications on the way in which the aggregate measurable cost savings calculation is used as one cap in the determination of the savings offset payment?

A. Yes, it has significant implications. Private payors and their members pay the savings offset payment, which is derived, in part, from the calculation of aggregate measurable savings. The SOP is supposed to be an offset to savings that have accrued to the benefit of those same private payors. If the aggregate measurable savings calculation calculates 100% of the "savings", but does not take into consideration that a significant portion of those "savings" go to governmental (not private) payors, the private payors will pay an amount of SOP that is greatly exaggerated relative to the calculated savings that actually could have accrued to the benefit of those private payers. This is obviously

inequitable and results in private payors subsidizing the savings that have accrued to governmental payors.

Q. Explain how Anthem BCBS pays physicians based on fee schedules.

A. Anthem BCBS utilizes the National CMS Resource Based Relative Value Scale published annually in the Code of Federal Regulations to determine the Relative Value Units (or RVUs) associated with specific procedure codes. The total RVUs associated with each procedure code contain components representing Physician Work, Practice Expense, and Malpractice Expense. The total RVUs are then multiplied by a standard conversion factor to produce the amount of total reimbursement due to the physician for the particular service. If a physician's charge is less than this amount, the lower amount (the actual charge) is paid rather than the RVU-based amount. Anthem BCBS does not adjust RVUs for geographical practice cost indices.

Q. Do you think that all of the calculated savings for physicians should be automatically applied in the SOP?

A. No. Just as is the case with hospitals, a significant amount of physician practice revenue is derived from governmental payors. This amount varies widely with specialty and geographic location, but the principle is the same. Any savings attributed to physicians occurring as a result of the operation of Dirigo Health must be proportioned to the payor mix in a way that recognizes that the healthcare system in Maine is comprised of more than just commercial payors.

Q. Understanding that you have had only very limited time to review the DHA's methodology presented in the Mercer Report, do you have a sense of the methodology that DHA proposes for the second assessment year?

A. Yes, it appears that the DHA will rely heavily on the Superintendent's Decision and Order from the first assessment year. As such, although we have not yet had an opportunity to examine DHA's proposed methodology in any level of detail, we have provided in our witness testimonies our perspectives under the assumption that the DHA's methodology will track the Superintendent's Decision from the first assessment year. We will almost certainly have follow-up testimony to offer at the hearing once we have an opportunity to review DHA's proposal in more detail.

Q. Do you have any preliminary comments based on the methodologies summarized in the Mercer Report?

A. Yes, particularly about the summary of the proposed CON/CIF methodology.

Q. What preliminary comments do you have about the CON/CIF methodology?

A. Mercer proposes to aggregate CON/CIF projects to create a purported historical average and, from that, attempt to discern whether actual CON/CIF activity in the measuring period demonstrates "savings". In my view, this proposed methodology ignores the reality that each CON/CIF project is unique and the determination of why a particular project was or was not completed requires a project by project analysis. Aggregating or averaging CON/CIF projects that can range from completely new hospitals, such as the future Mercy hospital relocation, to the installation of a new piece of equipment such as an MRI machine, does not create a meaningful average from which projected future cost growth can be established.

Q. Do you believe that every CON/CIF project not completed creates measurable savings?

A. No. There are many reasons, entirely unrelated to the operation of Dirigo Health, that a hospital may make the decision to forego completion of a new project. Also, such a

measurement assumes that all new projects increase costs. That is not true. Many hospital projects actually create savings to the hospital through greater efficiency or by driving down prices through increased competition. This is yet another reason why each potential project should be reviewed individually; lumping all projects together and attempting to create an artificial "average" dollar amount of hospital spend on new projects and deeming anything less than that amount to be "savings" ignores this reality and is not a legitimate or reasonable measure of real cost savings.

Q. Does the alternative methodology detailed in Mr. Keane's testimony better reflect true cost savings as a result of the operation of Dirigo Health as compared to either the methodology proposed by the DHA Board or approved by the Superintendent in the last proceeding?

A. First, let me say that I am not offering any legal opinions and, specifically, I am not offering any opinion of whether the expense per cost per case mix adjusted discharge caculates savings that are within the Dirigo law, as I understand that is one of the issues that is currently on appeal. With that said, I believe that the alternative set out in Mr. Keane's testimony is a vast improvement over last year's methodology because it contemplates follow-up with certain hospitals for which potential savings were identified to verify the cause(s) of those lower costs.

The methodology previously supported by the Dirigo Board simply counted all costs below a calculated line as "savings", and attributed all of those savings to the operation of Dirigo Health, without any contact (much less further investigation or analysis) with the hospitals that were identified as having achieved even the most significant of the "savings." In my experience, hospital costs go up and down somewhat erratically, year-over-year, especially when the hospitals are small and have large volume changes. Changes in volume drive unit costs (i.e., Expense per CMAD) up or down to degrees that are related to the size of the volume changes. Thus, counting all decreases or less than expected increases as Dirigo-related savings is not realistic and necessarily inflates the

savings calculation. In addition, I have found that hospitals are in the best position to opine on the cause(s) of their cost experience and they are willing to provide the information necessary to determine what factors influenced costs in any particular year, which would greatly assist in determining whether and to what extent some or all of any calculated cost savings are as a result of the operation of Dirigo Health. The alternative that Anthem BCBS is proposing is superior because it recognizes that hospital cost patterns are erratic and takes the next step of going to the source to verify that certain of the most significant reduced costs were actually the result of the operation of Dirigo Health.

Q. What steps should be taken to outreach to providers identified as producing results significantly outside of the corridor of expectations?

A. Under our recommended approach, those hospitals with anamolous results (i.e., those with results significantly outside of the corridor of expectations), should be contacted, presented with the results of the analysis and asked what factor(s) influenced costs over the course of the measuring year. It may well be that there were no factor(s), other than the operation of Dirigo Health, that caused the significant reduction in costs and, if a CMAD methodology is deemed to calculate savings that are within the Dirigo Legislation, those savings would be included. On the other hand, the applicable hospital may enumerate specific factor(s), other than the operation of Dirigo Health, that led to the anomalous result.

If factors other than the operation of Dirigo Health cannot account for some or all of the anomalous result, the question would be whether those reduced costs flowed through to insurers (and ultimately to consumers) in the form of reduced charges from the hospital. Again, there could be any number of reasons why a hospital may not pass on reduced costs, but the question whether the cost savings are embedded in the hospital's charges should be asked. That fact can also be verified by reviewing whether the insurance carriers have experienced a reduction in the level of charges for that particular hospital.

All of this information would be used to verify the savings that actually resulted from the operation of Dirigo Health.

Q. Does this conclude your testimony?

A. Yes.

Certificate of Service

I, Christopher T. Roach, Esq. certify that the foregoing Prefiled Testimony of Thomas Drottar was served this day upon the following parties via U.S. and Electronic Mail.

Board of Directors, Dirigo Health Agency Attn: Lynn Theberge Dirigo Health Agency 53 State House Station Augusta, Maine 04333-0053	D. Michael Frink, Esquire Curtis Thaxter Stevens Broder & Micoleau LLC One Canal Plaza P.O. Box 7320 Portland, ME 04112-7320
Dirigo Health Agency Attn: James Smith, Esquire—Hearing Officer 53 State House Station Augusta, Maine 04333-0053	William Stiles, Esquire Verrill Dana LLP One Portland Square P.O. Box 586 Portland, ME 04112-0586
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Dated: March 22, 2006

Christopher T. Roach, Esq.

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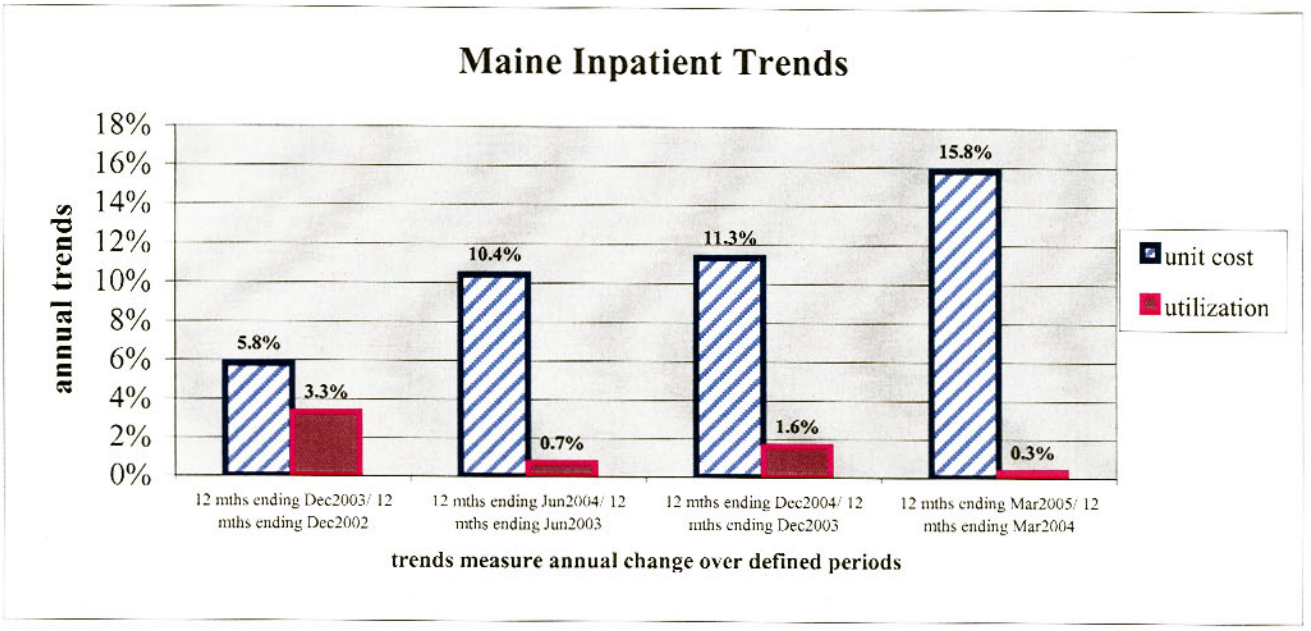
Anthem Health Plans of Maine, Inc.

Exhibit 5


Maine Inpatient Trends
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12%
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6%
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10.4%
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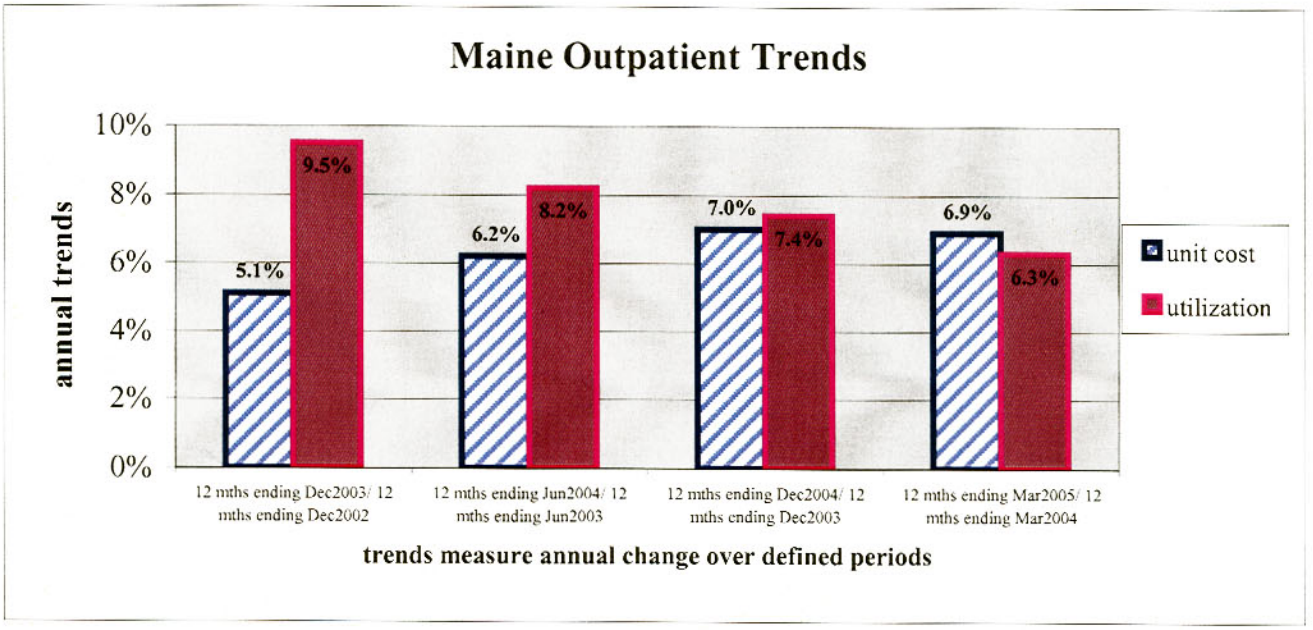
Maine Outpatient Trends
annual trends
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6%
4%
2%
0%
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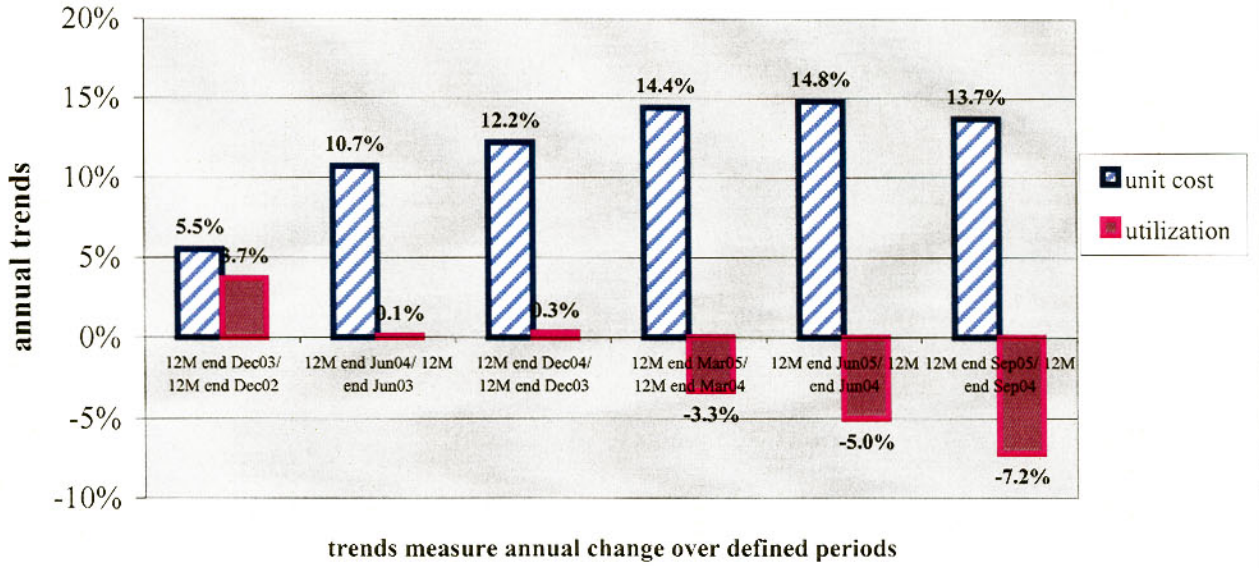
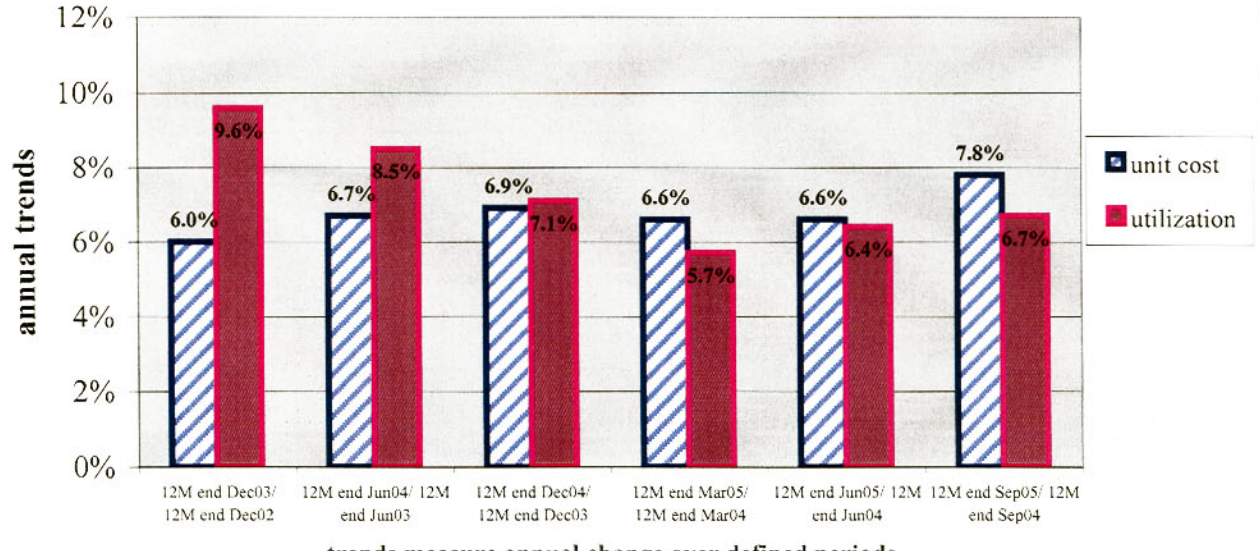
unit cost
utilization
trends measure annual change over defined periods

Maine Inpatient Trends



trends measure annual change over defined periods

Maine Outpatient Trends



trends measure annual change over defined periods

Exhibit 6

TRENDS

Health Spending Projections Through 2015: Changes On The Horizon

Stable trends through 2015 likely mask important changes to the U.S. health care system across payers and types of care.

by Christine Borger, Sheila Smith, Christopher Truffer, Sean Keehan, Andrea Sisko, John Poisal, and M. Kent Clemens

ABSTRACT: Growth in national health spending is projected to slow in 2005 to 7.4 percent, from a peak of 9.1 percent in 2002. Private health insurance premiums are projected to slow to 6.6 percent in 2005, with a rebound expected in 2007. The introduction of Medicare Part D drug coverage in 2006 produces a dramatic shift in spending across payers but has little net effect on aggregate spending growth. Health spending is expected to consistently outpace gross domestic product (GDP) over the coming decade, accounting for 20 percent of GDP by 2015. [*Health Affairs* 25 (2006): w61–w73 (published online 22 February 2006; 10.1377/hlthaff.25.w61)]

THIS YEAR'S OUTLOOK for national health spending calls for growth to average 7.2 percent over the coming decade—2.1 percentage points faster than projected average annual growth in gross domestic product (GDP) over the same interval. At this aggregate level, this year's projection does not differ notably from last year's projection, despite substantive revisions to historical data and the use of a new model for private personal health care spending.[1] The lack of change in the aggregate conceals the fact that there are substantial differences in the projection in various sectors, particularly prescription drugs and hospitals.

In 2005 national health spending growth is expected to decelerate to 7.4 percent from 7.9 percent in 2004 (Exhibits 1 and 2).[2] This is the third consecutive year of slowing spending growth since 2002. Underlying the projected 2005 slowdown is a projected dip in personal health care spending growth resulting from an anticipated slowdown in medical price inflation (personal health care deflator, Exhibit 2). We project that personal health care spending will edge down slightly in 2005 and 2006 and then will slow to 7.0 percent in 2007 as legislated Medicare payment adjustments are implemented. Projected growth rebounds immediately to 7.5 percent in 2008, and then gradually decelerates for the remainder of the forecast, as health spending reacts to a slowdown in income. Despite the cyclical nature of the projection, national health spending growth is forecast to outpace GDP growth each year during the next decade, causing health's share of GDP to rise from 16 percent in 2004 to 20 percent in 2015 (Exhibit 3).[3]

The authors are with the National Health Statistics Group, Office of the Actuary, Centers for Medicare and Medicaid Services, in Baltimore, Maryland. Christine Borger is an economist, as are Sheila Smith, Sean Keehan, and Andrea Sisko. John Poisal (DNHS@cms.hhs.gov) is the group's deputy director. Christopher Truffer and Kent Clemens are actuaries in the Medicare and Medicaid Cost Estimates Group.

DOI 10.1377/hlthaff.25.w61

EXHIBIT 1
National Health Expenditures (NHE), Aggregate And Per Capita Amounts, And Share Of Gross Domestic Product (GDP), Selected Calendar Years 1993–2015

Spending category	1993	2002	2003	2004	2005[a]	2006[a]	2010[a]	2015[a]
NHE (billions)	$916.5	$1,607.9	$1,740.6	$1,877.6	$2,016.0	$2,163.9	$2,879.4	$4,031.7
Health services and supplies	853.5	1,499.2	1,624.5	1,753.0	1,882.2	2,020.3	2,688.1	3,762.8
Personal health care	773.6	1,341.4	1,445.7	1,560.2	1,677.8	1,801.9	2,386.9	3,342.1
Hospital care	317.2	488.6	525.5	570.8	616.1	662.5	882.4	1,230.9
Professional services	280.7	503.2	543.3	587.4	631.3	680.0	903.4	1,261.4
Physician and clinical services	201.2	337.9	367.0	399.9	429.9	463.3	610.7	849.8
Other prof. services	24.5	45.7	49.1	52.7	55.8	59.7	78.5	109.4
Dental services	38.9	73.3	76.9	81.5	87.4	94.3	124.9	167.3
Other PHC	16.2	46.3	50.4	53.3	58.1	62.7	89.2	134.8
Nursing home and home health	87.3	140.0	148.6	158.4	170.6	181.5	232.8	320.5
Home health care[b]	21.9	34.3	38.1	43.2	48.9	53.1	72.3	103.7
Nursing home care[b]	65.4	105.7	110.4	115.2	121.7	128.4	160.5	216.8
Retail outlet sales of medical products	88.4	209.5	228.3	243.7	259.8	277.9	368.4	529.3
Prescription drugs	51.0	157.9	174.1	188.5	203.5	219.2	299.2	446.2
Durable medical equipment	13.5	20.8	22.1	23.0	23.7	24.9	29.5	36.2
Nondurable medical products	23.9	30.9	32.1	32.3	32.6	33.8	39.6	46.9
Program admin. and net cost of private health insurance	53.0	106.1	124.9	136.7	142.4	151.5	210.6	289.8
Government public health activities	26.8	51.7	54.0	56.1	62.0	67.0	90.7	130.9
Investment	63.0	108.8	116.1	124.6	133.8	143.6	191.3	268.9
Research[c]	16.4	32.5	35.6	39.0	42.0	45.2	60.2	81.0
Structures and equipment	46.6	76.2	80.5	85.7	91.8	98.4	131.1	187.9
NHE per capita	$3,461.3	$5,485.0	$5,879.4	$6,280.3	$6,683.0	$7,110.3	$9,147.7	$12,320.4
Population (millions)	264.8	293.2	296.1	299.0	301.7	304.3	314.8	327.2
GDP, billions of dollars	$6,657.4	$10,469.6	$10,971.2	$11,734.3	$12,450.1	$13,134.8	$16,026.4	$20,197.9
Real NHE[d]	$1,041.7	$1,543.2	$1,637.3	$1,721.0	$1,801.0	$1,889.7	$2,284.7	$2,827.4
Chain-weighted GDP index	0.88	1.04	1.06	1.09	1.12	1.15	1.26	1.43
PHC deflator[e]	0.81	1.08	1.12	1.16	1.20	1.25	1.45	1.75
NHE as percent of GDP	13.8%	15.4%	15.9%	16.0%	16.2%	16.5%	18.0%	20.0%

SOURCES: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group; and U.S. Department of Commerce, Bureau of Economic Analysis and Bureau of the Census.

NOTE: Numbers might not add to totals because of rounding. 1993 marks the beginning of the shift to managed care.

[a] Projected.

[b] Freestanding facilities only. Additional services are provided in hospital-based facilities and counted as hospital care.

[c] Research and development expenditures of drug companies and other manufacturers and providers of medical equipment and supplies are excluded from "research expenditures" but are included in the expenditure class in which the product falls.

[d] Deflated using GDP chain-type price index (2000 = 100.0).

[e] Personal health care (PHC) chain-type index is constructed from the producer price index for hospital care, nursing home input price index for nursing home care, and consumer price indices specific to each remaining PHC component (2000 = 100.0).

The anticipated slowdown in medical care price growth is expected to be transitory; we expect medical price inflation to rebound slightly to 3.8 percent in 2006. Our outlook for medical inflation for the remainder of the projection period includes sustained growth that

EXHIBIT 2
National Health Expenditures (NHE), Average Annual Percentage Growth From Prior Year Shown, Selected Calendar Years 1993–2015

Spending category	1993[a]	2002	2003	2004	2005[b]	2006[b]	2010[b]	2015[b]
NHE	11.5	6.4	8.2	7.9	7.4	7.3	7.4	7.0
Health services and supplies	11.7	6.5	8.4	7.9	7.4	7.3	7.4	7.0
Personal health care	11.5	6.3	7.8	7.9	7.5	7.4	7.3	7.0
Hospital care	11.2	4.9	7.5	8.6	7.9	7.5	7.4	6.9
Professional services	12.0	6.7	8.0	8.1	7.5	7.7	7.4	6.9
Physician and clinical services	12.3	5.9	8.6	9.0	7.5	7.8	7.2	6.8
Other prof. services	16.4	7.2	7.5	7.4	5.9	6.9	7.1	6.9
Dental services	9.7	7.3	4.8	6.1	7.2	7.9	7.3	6.0
Other PHC	11.8	12.4	8.7	5.8	9.1	7.9	9.2	8.6
Nursing home and home health	14.3	5.4	6.1	6.6	7.7	6.4	6.4	6.6
Home health care[c]	22.1	5.1	11.1	13.3	13.2	8.6	8.0	7.5
Nursing home care[c]	12.9	5.5	4.5	4.3	5.6	5.5	5.7	6.2
Retail outlet sales of medical products	9.7	10.1	9.0	6.7	6.6	7.0	7.3	7.5
Prescription drugs	10.2	13.4	10.2	8.2	8.0	7.7	8.1	8.3
Durable medical equipment	9.6	4.9	6.4	4.0	3.3	5.1	4.3	4.1
Nondurable medical products	9.0	2.9	4.2	0.4	1.1	3.5	4.1	3.4
Program admin. and net cost of private health insurance	13.7	8.0	17.7	9.4	4.2	6.4	8.6	6.6
Government public health activities	13.7	7.6	4.4	4.0	10.5	8.0	7.9	7.6
Investment	9.4	6.3	6.7	7.3	7.4	7.3	7.4	7.0
Research[d]	9.7	7.9	9.5	9.3	7.9	7.7	7.4	6.1
Structures and equipment	9.3	5.6	5.5	6.5	7.1	7.2	7.5	7.5
NHE per capita	10.4	5.2	7.2	6.8	6.4	6.4	6.5	6.1
Population (millions)	1.0	1.1	1.0	1.0	0.9	0.9	0.8	0.8
GDP, billions of dollars	8.4	5.2	4.8	7.0	6.1	5.5	5.1	4.7
Real NHE[e]	5.9	4.5	6.1	5.1	4.7	4.9	4.9	4.4
Chain-weighted GDP index	5.2	1.9	2.0	2.6	2.6	2.3	2.4	2.5
Personal health care deflator[f]	7.3	3.2	3.7	4.1	3.5	3.8	3.8	3.8

SOURCES: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group; and U.S. Department of Commerce, Bureau of Economic Analysis and Bureau of the Census.

NOTES: GDP is gross domestic product. Numbers might not add to totals because of rounding. 1993 marks the beginning of the shift to managed care. Growth rates are calculated consistent with the National Health Expenditure Accounts methodology. For example, the 2015 growth rate above is equal to the level of 2015 expenditures over the level of 2010 expenditures raised to the one-fifth power (the average growth over five years).

[a] Average annual growth from 1970 through 1993.

[b] Projected.

[c] Freestanding facilities only. Additional services are provided in hospital-based facilities and counted as hospital care.

[d] Research and development expenditures of drug companies and other manufacturers and providers of medical equipment and supplies are excluded from "research expenditures" but are included in the expenditure class in which the product falls.

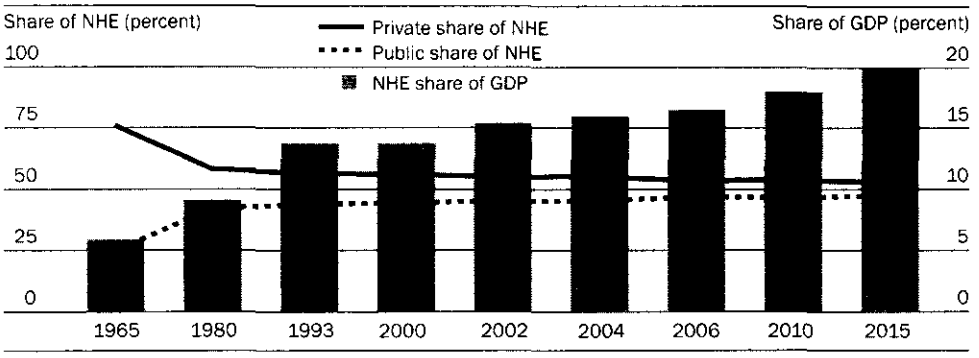
[e] Deflated using GDP chain-type price index (2000 = 100.0).

[f] Personal health care (PHC) chain-type index is constructed from the producer price index for hospital care, nursing home input price index for nursing home care, and consumer price indices specific to each remaining PHC component (2000 = 100.0).

averages 3.8 percent per year between 2007 and 2015. The trend over the past three years is mixed following unusually slow growth in the mid-1990s and rapid acceleration during 1998–2001. This pattern tracks closely with measures of health-sector input prices, with a lag of one to two years.

Projected to be 8.0 percent in 2005, growth in public spending on personal health care is expected to continue to outpace growth in private spending.[4] The 2005 growth rate reflects the effects of the Medicare Prescription

EXHIBIT 3
National Health Expenditures (NHE) Share Of Gross Domestic Product (GDP) And Private And Public Shares Of NHE, Selected Years 1965–2015

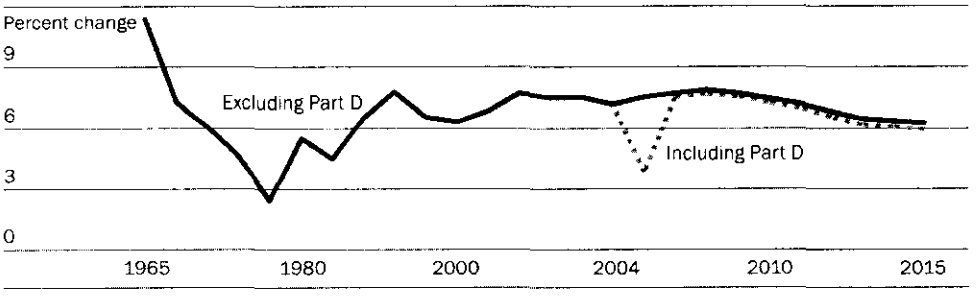


SOURCE: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group.
NOTES: The left axis (public and private spending's share of NHE) relates to the two line graphs. The right axis (NHE share of GDP) relates to the gray-shaded bars. Data for 2006, 2010, and 2015 are projections.

Drug, Improvement, and Modernization Act (MMA) of 2003 that are distinct from the addition of Medicare drug coverage (Part D).[5] The introduction of Part D in 2006 causes the growth rate of public personal health care spending to jump to 11.8 percent, because Part D is anticipated to primarily represent a shift of spending to the public sector.[6] In 2007, projected public personal health care spending growth is expected to be slightly below trend at 6.5 percent. From 2008 to 2011, growth rates average 7.2 percent. In the last four years of the forecast, growth averages 7.8 percent, driven primarily by the expiration of legislated Medicare payment cuts to physicians.

Growth in personal health care spending from private sources is expected to slow from 7.5 percent in 2004 to 7.2 percent in 2005, driven by the anticipated slowdown in medical price inflation. Projected growth falls to 3.9 percent in 2006 because of a shift in the source of payments for prescription drugs with the start of Part D. Excluding the effects of Part D, projected private growth would have edged upward slightly in 2006, reflecting increased rates for growth in both utilization and medical price inflation (Exhibit 4). Private personal health care spending growth is projected to accelerate between 2006 and 2008—peaking at 7.7 percent—and then decelerate for the rest

EXHIBIT 4
Private Personal Health Care Spending, Excluding And Including The Impact Of Medicare Part D, 1990–2015



SOURCE: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group.
NOTE: Data from 2005 through 2015 are projections.

of the period, ending at 6.0 percent in 2015. From 2007 onward, the cyclical pattern is driven by the projection for real per capita spending (volume and intensity of services), which slows in lagged response to changes in real income.

Hospital spending growth is expected to exceed growth in personal health care spending in 2005, just as it did in 2004 (Exhibit 2). This year's projection is noticeably higher than last year's, reflecting an upward revision to anticipated growth in use. As a result, hospital spending is now expected to roughly keep pace with personal health care spending over the coming decade. On the other hand, our outlook for prescription drug spending growth is noticeably lower than last year's, because we revised downward our projection for growth in use. The net effect is that the hospital share of total health spending is flat, instead of declining as it did in last year's projection, and drugs' share rises just one percentage point instead of almost four percentage points.

Noteworthy changes for both payers and providers may lie within the coming decade as our health care system responds to building pressure from such forces as the onset of Medicare Part D, the aging of our society, and the expensive (and unpredictable) nature of new technologies. With national health spending growth in excess of GDP growth each year over the next decade, these changes could force payers and providers to reexamine fundamental questions regarding the delivery and financing of health care services.

Factors Contributing To Growth

■ **Demand side.** Projections for aggregate national health spending reflect a range of underlying assumptions for factors influencing supply and demand. Demographic shifts, declining insurance coverage, and changes in the nature of insurance (such as the rise of health savings accounts, or HSAs) are some demand-side factors influencing this year's projected pattern of growth in health spending. Population aging accounts for a small but rising share during the next ten years: 0.4 percentage points of growth in 2004 and 0.6 percentage points in 2015. As the leading edge of the baby-boom generation becomes eligible for Medicare, the population over age sixty-five becomes proportionately younger, subtracting from growth in Medicare per beneficiary spending.

Changes in the structure of private insurance coverage are in early stages of implementation (for example, HSAs and the proliferation of disease management programs). However, the net impact on cost containment is likely to be far smaller than that seen from the massive shift toward managed care during the mid-1990s. Therefore, growth in medical spending is projected to continue at rates well above the lows of the mid-1990s.

■ **Supply side.** On the supply side, growth in input prices is expected to average below the peak of 2001, but somewhat higher than rates seen during the previous decade. In addition, we expect a gradual increase in the rate of medical price inflation relative to input price inflation following several years (1997–2004) when output prices generally grew at rates below input prices. This expectation is informed by the assumption that most of the recent reversal in the input-output price pattern is attributable to one-time improvements in efficiency.

The diffusion of new medical innovation is assumed to continue to drive spending upward. We expect that this factor will be tempered by continuing attempts to increase efficiency in the application of new technologies and to target them more appropriately to the populations most likely to benefit, as information is gathered and applied more quickly.

Model And Assumptions

The national health spending projections are generated within a "current law" framework that incorporates actuarial, econometric, and judgmental inputs. Medicare projections are primarily based on the 2005 Medicare Trustees' report; Medicaid spending projections are consistent with the report's assumptions.[7] For prescription drugs, we incorporated the latest cost estimates and assumptions that appear in the president's fiscal year 2007 budget.[8] The projections for both private

and public spending use the economic and demographic assumptions from the 2005 Medicare Trustees' report, updated to reflect the latest historical data.[9]

Each year we review our econometric models.[10] To produce this year's report, we revised our model for real per capita personal health care spending. The new model includes a constant term that is intended to capture the exogenous contribution of medical innovation and other nonspecified factors to growth. (The constant contributes 1.2 percentage points to growth in real per capita private personal health care spending over the projection period.) Coefficients on income and prices were affected by the model change: The model is less responsive to fluctuations in income and more sensitive to relative medical price inflation.

Forecasting is contingent on assumptions about macroeconomic conditions and their relationship to health care spending; thus, our projections are always subject to much uncertainty. The uncertainty associated with this set of projections is even greater because we have no historical experience with Part D.

Spending Outlook

■ **Medicare.** Total Medicare spending growth is expected to slow slightly in 2005 (Exhibit 5). Medicare hospital and physician spending growth rates are projected to be 8.5 percent and 8.3 percent, respectively, in 2005. Medicare spending growth is expected to spike to 25.2 percent in 2006, as the Part D benefit is implemented. Total Medicare spending growth is projected to slow again to 5.4 percent in 2007 because of adjustments to managed care payments but is expected to resume increasing thereafter, averaging about 7.5 percent between 2008 and 2015.

The pattern of Medicare spending growth for physician services is largely dictated by the Sustainable Growth Rate (SGR) system, which determines the payment updates for the physician fee schedule. The SGR requires that future physician payment updates be adjusted for past actual physician spending relative to a target spending level. In the absence of MMA, the SGR would have led to large negative physician updates in 2004 and 2005. However, MMA established minimum updates of 1.5 percent in 2004 and 2005, but it did not alter the target spending levels. Therefore, our projection includes payment cuts for physicians beginning in 2006 and extending through 2013, when legislated cuts expire and payment updates are increased, which causes total Medicare spending to accelerate. Although we view these projected reductions as unlikely to occur before changes in legislation intervene, our Medicare projections are made on a current law basis, so we do not assume a legislative change to the physician payment system. As a result, our Medicare physician spending projections are likely understated.

In 2004 and 2005, MMA increased payments to managed care plans. Beginning in 2006, our projection includes the assumption of a shift in enrollment from traditional fee-for-service (FFS) to managed care plans. To be consistent with assumptions in the Medicare Trustees' report, about 32 percent of Medicare enrollees are projected to be in managed care plans by 2015, compared with 12 percent in 2004.[11] In 2007, Medicare managed care plan payments are expected to be reduced because of revisions to risk adjusters. The adjustments are expected to be approximately −7 percent. Consequently, the pattern of projected Medicare spending growth includes a noticeable dip in 2007, which is clearly visible across several sectors. Medicare spending growth is expected to trend back upward, rising to 8.8 percent by 2015.

■ **Medicaid.** We project that combined state and federal Medicaid spending growth in 2005 will slow for the fourth consecutive year to 7.7 percent. Growth in Medicaid real per enrollee spending (volume and intensity of services) is projected to increase from 1.0 percent in 2004 to 2.8 percent in 2005. Enrollment growth is expected to decelerate, falling to 2.1 percent in 2005 from 4.2 percent in 2004. This slowdown is primarily attributable to improving economic conditions. Nonetheless, states still face budget troubles as Medicaid continues to grow. The temporary enhanced federal matching rate, part of the Jobs

EXHIBIT 5
National Health Expenditures (NHE), By Source Of Funds, Amounts, And Average Annual Growth From Prior Year Shown, Selected Calendar Years 1993–2015

Source of funds	1993	2002	2003	2004	2005[a]	2006[a]	2010[a]	2015[a]
NHE (billions)	$916.5	$1,607.9	$1,740.6	$1,877.6	$2,016.0	$2,163.9	$2,879.4	$4,031.7
Private funds	514.2	881.4	957.2	1,030.3	1,101.4	1,148.4	1,544.7	2,116.4
Consumer payments	442.3	763.0	829.7	894.2	955.2	991.2	1,334.1	1,818.1
Out-of-pocket payments	145.3	210.8	223.5	235.7	248.8	246.2	316.3	421.0
Private health insurance	297.0	552.2	606.3	658.5	706.4	745.0	1,017.7	1,397.1
Other private funds	71.9	118.4	127.5	136.1	146.2	157.1	210.6	298.3
Public funds	402.3	726.5	783.4	847.3	914.6	1,015.5	1,334.7	1,915.3
Federal	277.7	509.5	554.4	600.0	645.9	742.0	971.4	1,407.8
Medicare	148.4	266.3	283.8	309.0	335.5	420.1	536.0	792.0
Medicaid[b]	76.8	147.3	162.5	173.1	181.5	184.0	258.9	384.4
Other federal[c]	52.5	95.8	108.1	118.0	128.9	137.8	176.5	231.3
State and local	124.7	217.1	229.0	247.3	268.7	279.2	371.2	519.4
Medicaid[b]	45.6	101.7	108.7	119.6	133.6	136.0	191.5	285.3
Other state and local[c]	79.1	115.4	120.3	127.7	135.0	143.2	179.7	234.1
Average annual growth	**1993[d]**	**2002**	**2003**	**2004**	**2005[a]**	**2006[a]**	**2010[a]**	**2015[a]**
NHE	11.5%	6.4%	8.2%	7.9%	7.4%	7.3%	7.4%	7.0%
Private funds	11.0	6.2	8.6	7.6	6.9	4.3	7.7	6.5
Consumer payments	11.0	6.2	8.7	7.8	6.8	3.8	7.7	6.4
Out-of-pocket payments	8.0	4.2	6.0	5.5	5.6	-1.0	6.5	5.9
Private health insurance	13.7	7.1	9.8	8.6	7.3	5.5	8.1	6.5
Other private funds	11.1	5.7	7.7	6.8	7.4	7.5	7.6	7.2
Public funds	12.2	6.8	7.8	8.2	7.9	11.0	7.1	7.5
Federal	12.7	7.0	8.8	8.2	7.7	14.9	7.0	7.7
Medicare	13.7	6.7	6.6	8.9	8.6	25.2	6.3	8.1
Medicaid[b]	15.4	7.5	10.3	6.6	4.9	1.4	8.9	8.2
Other federal[c]	9.0	6.9	12.8	9.1	9.2	6.9	6.4	5.6
State and local	11.3	6.4	5.5	8.0	8.7	3.9	7.4	7.0
Medicaid[b]	13.6	9.3	6.9	10.0	11.8	1.8	8.9	8.3
Other state and local[c]	10.4	4.3	4.3	6.1	5.8	6.0	5.8	5.4

SOURCE: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group.

NOTES: Numbers might not add to totals because of rounding. 1993 marks the beginning of the shift to managed care. Growth rates are calculated consistent with the National Health Expenditure Accounts methodology. For example, the 2015 growth rate above is equal to the level of 2015 expenditures over the level of 2010 expenditures raised to the one-fifth power (the average growth over five years); 2015 growth rate is shorthand for 2010–2015 growth rate.

[a] Projected.

[b] Includes Medicaid and State Children's Health Insurance Program (SCHIP) expansion (Title XIX).

[c] Includes Medicaid SCHIP expansion (Title XXI).

[d] Average annual growth from 1970 through 1993.

and Growth Tax Reconciliation Act of 2003, ended in June 2004, and this is expected to exacerbate states' fiscal constraints. Because of the changes in matching rates, the 2005 state Medicaid spending growth rate is projected to be greater than its federal counterpart.

Ongoing budget constraints continue to pressure both the state and federal governments to seek a variety of cost containment measures. Every state is pursuing at least one such measure for either 2005 or 2006, and many are seeking more than one. The most popular of the states' strategies are focused on prescription drug costs, freezing or reducing provider payment rates, and new restrictions on benefits or enrollment.[12] The federal government is also pursuing strategies to control Medicaid spending growth. In 2005 a biparti-

san commission on Medicaid reform formed by Congress and the secretary of health and human services (HHS) recommended proposals designed to save $11 billion in federal Medicaid spending over the next five years.[13] The proposals generally targeted savings on drug spending and long-term care.

With the implementation of the Medicare Part D benefit in 2006, we expect that Medicaid drug spending will decrease, as drug spending for those who are eligible for both Medicaid and Medicare will shift from Medicaid to Medicare Part D. We anticipate an increase in Medicaid enrollment in 2006, as Part D enrollment efforts will likely reveal that some Medicare beneficiaries are also eligible for Medicaid; however, we expect that the assumed decrease in drug spending will dominate the overall Medicaid trend, with combined state and federal Medicaid spending growing only 1.5 percent in that year.[14] Beginning in 2007, Medicaid spending growth is projected to rebound to 8.5 percent and average 8.6 percent per year until 2015, with state and federal rates at fairly similar levels.

■ **Government public health.** We project that government public health spending growth will accelerate in 2005 to 10.5 percent, compared with 4.0 percent in 2004 (Exhibit 2). This acceleration is primarily the result of additional funding associated with the public health response to Hurricanes Katrina and Rita. Federal public health spending is projected to increase 24.3 percent to $11.3 billion in 2005, compared with 5.7 percent in 2004. Increased funding for disaster relief for the U.S. Centers for Disease Control and Prevention (CDC) is the primary cause of this acceleration.[15] State and local public health spending is expected to rise 7.9 percent in 2005, well above the 2004 growth rate of 3.7 percent.

Between 2006 and 2015, growth in government public health spending is projected to average 7.8 percent per year. In addition to disaster response, a sizable portion of this spending will be allocated to improvements in the U.S. public health system, including protections against bioterrorism. Also, the CDC budget is expected to be increased in an effort to prevent the spread of viruses such as the avian flu.[16] Despite strong growth, though, government public health spending's share of national health spending is projected to rise only slightly, from 3.0 percent in 2004 to 3.2 percent in 2015.

■ **Private health insurance.** Private health insurance premiums are expected to grow 6.8 percent in 2005, down from 8.4 percent in 2004. This is the third consecutive year in which premium growth will have slowed since its most recent peak of 11.5 percent in 2002. Private health insurance has historically exhibited a cyclical pattern (the underwriting cycle), where growth in premiums first undershoots and then overshoots growth in the underlying medical spending trend.[17] We expect a trough in the underwriting cycle in 2005, with growth in premiums per enrollee falling below growth in medical benefit spending per enrollee.

The 4.7-percentage-point slowdown in premium growth since 2002 is attributable to two factors, each of which accounts for about half of the cumulative deceleration. The first is the underwriting cycle. The second is slower growth in projected medical benefits per enrollee: Growth fell from 9.8 percent in 2002 to an estimated 7.4 percent in 2005. While medical price inflation edged downward over this period as input prices eased, the primary factor accounting for the slowdown was a deceleration in use. This reflects the sharp slowdown in drug usage, the reimposition of some elements of utilization management, the impact of rising copayments and deductibles on consumer demand, and the expectation of an increase in the uninsured population.[18]

With the implementation of Medicare Part D, 2006 is an anomalous year. Part D breaks the underlying trends, causing both premium and benefit growth to fall to approximately 5.0 percent. The slowdown in projected benefit growth is expected to be reversed in 2007 as utilization accelerates. A projected upturn in the underwriting cycle in 2007 will compound the forces pushing premium growth upward, peaking at 8.3 percent in 2009. Tighter labor markets in 2004 led to a slight rise in private

insurance coverage; however, we anticipate continued attrition in coverage rates throughout our projection period.

■ **Out-of-pocket spending.** Growth in out-of-pocket payments is expected to remain virtually unchanged at 5.6 percent in 2005 as overall private spending growth slows (Exhibit 5). The rate of growth is expected to decrease sharply in 2006 with the advent of Part D. Throughout the period, growth in out-of-pocket payments is projected to remain below growth in private health insurance spending.

Rising out-of-pocket costs have received a great deal of attention. However, looking back over the past ten years, out-of-pocket spending increased faster than total private spending only between 1997 and 1998. Although the rate of increase in out-of-pocket payments might not quite match that of private premiums, it has been noticeable to consumers, who have historically been sheltered from much of the bite of rising health costs by a continuous decline in the out-of-pocket share of spending. During the coming decade, we expect that growth in out-of-pocket spending will continue to converge toward growth in overall private spending; nonetheless, the out-of-pocket share of personal health care spending is projected to decline from 15.1 percent in 2004 to 12.6 percent by 2015.[19]

HSAs and similar types of consumer-directed health plans continue to grow rapidly, but from a very small base, accounting for just 1 percent of all covered employees in 2005.[20] Despite their relatively small scale, HSAs are beginning to have an effect on health insurance plan characteristics, with a range of large insurers launching efforts to provide greater transparency in the pricing of medical services.[21] The goal of these new plans is to institute greater consumer awareness of the cost of various health care services.[22]

Spending Outlook, By Sector

■ **Hospitals.** Total hospital spending growth is projected to be 7.9 percent in 2005, more than 1.5 percentage points higher than GDP growth (Exhibit 2). On average, total hospital spending growth is expected to remain more than two percentage points higher than GDP growth between 2006 and 2015.

Public- and private-sector spending trends are quite different. For private payers, hospital spending growth is expected to slow from 9.6 percent in 2004 to 8.5 percent in 2005 because of a decline in hospital price inflation. After 2005, the projection climbs to 9.0 percent in 2006 and averages 7.9 percent for the remainder of the period, reflecting a projected slowdown in utilization. For public payers, hospital spending growth is expected to slow slightly from 7.9 percent in 2004 to 7.5 percent in 2005 and to 6.4 in 2006. This downward trend reflects a projected slowdown in Medicaid spending growth, as enrollment growth decelerates. Public hospital spending growth falls to 5.5 percent in 2007 because of legislated adjustments to Medicare managed care payments. After 2007, this growth accelerates, rising to 6.8 percent by 2015.

This year's projection for private real per capita hospital spending—a measure that captures volume and intensity of services—is much higher than last year's. It is expected to peak in 2006 at 4.1 percent and is then expected to average 2.8 percent each year between 2007 and 2015. The change in outlook reflects both revisions to the historical data and a new interpretation of the fundamentals underlying the ongoing urban hospital construction boom.[23] The latter years of the forecast reflect gradually slowing growth rates, as we expect that efforts to place more of the financial burden associated with the provision of hospital care on consumers will have a modest impact. Despite the slowdown, private hospital spending as a share of private personal health care spending is up four percentage points by the end of the projection period (33 percent in 2015, from 29 percent in 2004). Given the downturn in public spending growth, total hospital spending as a share of total personal health care remains flat at 37 percent over the entire forecast period.

■ **Prescription drugs.** The slowdown in drug spending continued in 2004 with growth at 8.2 percent—ten percentage points below the peak rate of growth in 1999 (Exhibit 2).[24]

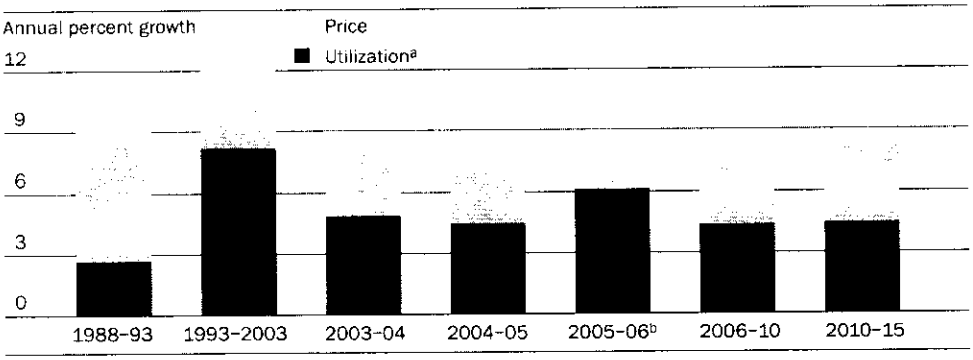
This historical estimate, along with data already received for 2005, has significantly changed the drug spending outlook. Average annual spending growth for the projection period is anticipated to be 8.2 percent, two percentage points below last year's projection.[25]

Despite our expectation of a mild acceleration in drug price growth in 2005, we project that the spending slowdown will continue, with growth forecast at 8.0 percent for 2005. This deceleration is driven by a slowdown in drug usage. Privately insured people are being subjected to further cost sharing in the form of higher copayments; moreover, employers are increasingly using coinsurance systems—in which the out-of-pocket share of the cost tends to rise faster than with copayments—to moderate spending trends.[26] Drug safety concerns likely played a role in continuing the slower spending growth in 2005.

For 2006, we project that total prescription drug spending will grow 7.7 percent (Exhibit 6). This projected growth rate is 0.4 percentage points below our forecast that excluded the effects of Medicare Part D. Including Part D lowers the forecast for total drug spending because discounts and rebates associated with the new program are larger than we had expected.[27] The major effect of this new benefit is still anticipated to be a shift in funding from private payers and Medicaid to Medicare: The Medicare share is forecast to rise from 2 percent in 2005 to 27 percent in 2006. Absent Part D, projected growth in drug prices would account for 3.8 percentage points of the overall 8.1 percent growth in 2006. Including the Part D benefit, drug price growth accounts for just 1.5 percentage points of the 7.7 percent growth rate forecast for 2006. Incorporating the effects of Part D lowers the growth rate of total spending, because we expect that drug prices for many seniors will fall as they gain access to discounted drug prices through private plans. These lower prices are nearly offset by higher assumed drug usage among seniors who had limited or no drug coverage before 2006.

Although the effect of Part D in 2006 is quite similar to our previous projection, we have the benefit of an additional data source: information provided by insurers that have contracted with the Centers for Medicare and Medicaid Services (CMS) to provide drug coverage to beneficiaries. Compared with our previous projection, our assumption regarding the level of discounts and rebates in 2006 has increased from 15 percent to 27 percent. Also, we have assumed that these discounts and rebates will remain constant throughout the projection period. The effect on spending of assumed higher discounts is greater than the effect of increased utilization, causing drug spending growth to decrease slightly when the

EXHIBIT 6
Factors Contributing To Total Prescription Drug Spending Growth, Various Time Periods 1988–2015



SOURCE: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group.
[a] Utilization also includes the effects of intensity and population growth.
[b] Without the effect of Medicare Part D, overall growth would be 8.1 percent (3.8 percent price, 4.3 percent utilization).

effects of Part D are incorporated.[28] We anticipate that Medicare drug coverage will not have a major impact on the overall drug spending growth rate after 2006.

The long-term outlook for prescription drugs contains factors that are expected to increase drug spending growth as well as factors that are expected to constrain growth. The former include practice patterns that involve prescribing existing drugs to a larger segment of the population and high-cost specialty drugs designed to treat rare conditions.[29] The latter include the increased use of generic drugs—which should increase over the next few years as generics replace certain blockbuster drugs whose patents will soon expire—and increased cost sharing in the form of rising copayments and additional deductibles or both.[30] Our current projection calls for these factors to mostly offset each other. As a result, we expect that drug spending growth will remain in the range of 8.0–8.4 percent from 2007 to 2015.

■ **Physician and clinical services.** We project that growth in total physician spending will decelerate from 9.0 percent in 2004 to 7.5 percent in 2005 (Exhibit 2). Both private and public spending growth rates are expected to decelerate—from 8.5 percent in 2004 to 7.1 percent in 2005 and from 9.9 percent in 2004 to 8.2 percent in 2005, respectively. We expect that private growth will rebound in 2006 to 7.8 percent and reach 8.3 percent by 2008, following the pattern in total private spending during the rest of the projection period. The 2005 slowdown is driven by an expected decrease in the growth of physician services prices, from 4.0 percent in 2004 to 3.4 percent in 2005, as well as an expected decline in real per capita spending growth, as the latter responds with a lag to the 2004 downturn in income. As discussed, the Medicare physician spending projection assumes no change to the SGR system; consequently, beginning in 2006, our forecast is likely to understate actual future spending.

■ **Long-term care.** We project that nursing home spending growth will accelerate in 2005 to 5.6 percent, from 4.3 percent in 2004 (Exhibit 2). Public spending drives the acceleration, with faster growth rates in both Medicare and Medicaid. We project that Medicaid spending will grow faster than either Medicare or private spending, averaging 7.0 percent per year during the projection period. By the end of the period, we expect Medicaid to pay for nearly half of all nursing home spending, compared with less than 45 percent in 2004. We also expect that the effects of an aging population will be most evident in nursing home spending by then, with a slight acceleration in public spending. Overall, we expect the one-year growth rates in nursing home spending to increase from 6.1 percent in 2011 to 6.3 percent by 2015. This contrasts with the slow deceleration in total personal health care spending over the same time period.

Home health spending is projected to grow 13.2 percent in 2005 (Exhibit 2). This continued strong growth is driven by increases in public spending, which now represents about three-fourths of home health spending and is projected to grow to more than 80 percent by 2015. Home health services, a relatively small percentage of total national health spending, are projected to again exhibit the fastest rate of growth among all sectors in 2005.

Growth in Medicare home health spending is expected to slow to 15.3 percent in 2005, from 19.0 percent in 2004. Despite this moderation in growth, the 2005 forecast marks the fifth consecutive year of double-digit increases. We expect growth to remain above 10 percent in 2006 and then to decelerate and settle to an average growth of 6.9 percent for the remainder of the projection period. The growth pattern in home health agency–based hospice care spending is a major driver of this deceleration. A shift in enrollment from FFS to Medicare managed care programs will also drive this trend. Nonetheless, Medicare is expected to remain a dominant payer for home health services.

Medicaid home health spending growth is expected to accelerate 2.4 percentage points in 2005, to 18.6 percent. We expect growth to decelerate in 2006 to 8.9 percent and then to average 10.7 percent through 2015. Medicaid's

share of home health spending is expected to increase 10.9 percentage points by 2015. This trend reflects a shift in care setting preferences by both beneficiaries and payers: the movement away from institutional care toward home care.[31] A return to normal federal/state cost sharing following the 2004 expiration of an enhanced federal matching rate drives the acceleration in the state and local share of Medicaid spending.

Finally, we expect private spending growth for home health care to accelerate to 4.2 percent in 2005, from 2.4 percent in 2004. Among private payers, private health insurance is expected to continue to constitute a higher share of spending than out-of-pocket payments and other private payers.

Concluding Comments

The relatively stable trends we expect through 2015 likely obscure dramatic changes to our health care system during the next decade. With the advent of the prescription drug benefit in 2006 and the oldest baby boomers enrolling during the next decade, Medicare is expanding quickly. The continued growth of Medicaid spending makes this source of health care funding an increasingly important issue for both the states and the federal government. Employers, meanwhile, are facing key decisions about the level and types of benefits to offer their employees and retirees, given rising health care costs and premiums. Private insurers continue to create new cost-sharing measures while also offering high-deductible health plans, both of which could change the dynamic of who pays for health care. With the continuing advancements in medical technology and treatments, the costs of and demand for health care are expected to increase. Given this confluence of changes for both public and private payers and our projection that health care spending growth will outpace the growth of the economy, we anticipate that society will again need to confront the underlying questions about the supply of and demand for health care services, as we anticipate that one in every five dollars will be devoted to this sector by 2015.

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NOTES

1. S. Heffler et al., "U.S. Health Spending Projections for 2004–2014," *Health Affairs* 24 (2005): w74–w85 (published online 23 February 2005; 10.1377/hlthaff.w5.74).
2. C. Smith et al., "National Health Spending in 2004: Recent Slowdown Led by Prescription Drug Spending," *Health Affairs* 25, no. 1 (2006): 186–196.
3. The National Health Expenditure Accounts (NHEA) benchmark for the 2004 accounts changed the methodology for construction (renamed "structures") and added equipment purchased by the health sector. As a result, structures and equipment for 2003 are $56 billion higher in the most recent NHEA than in the 2003 NHEA. This change results in national health spending being a higher share of GDP in all years and 0.5 percentage points higher in 2003.
4. Relatively faster growth in Medicare spending reflects enrollment growth; however, projected growth in private health insurance spending per enrollee exceeds both per beneficiary Medicare and per enrollee Medicaid spending for 2005.
5. These include Transitional Assistance associated with the Medicare prescription drug discount card program and increased payments to physicians, rural hospitals, and managed care plans.
6. For a more detailed discussion of the shift in funding expected with the beginning of the Part D benefit, see Heffler et al., "U.S. Health Spending Projections for 2004–2014."
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8. Office of Management and Budget, *Budget of the United States Government, Fiscal Year 2007*, http://www.whitehouse.gov/omb/budget (accessed 6 February 2006).
9. We used available historical data (as of November 2005) and updated near-term forecasts to transition to the 2005 Medicare Trustees' report assumptions.

10. The results of our aggregate model of overall private personal health care spending are reconciled with separate models for private spending in each sector. For a more complete description of our projections model, see Centers for Medicare and Medicaid Services, "Projections of National Health Expenditures: Methodology and Model Specification," 11 March 2005, http://www.cms.hhs.gov/NationalHealthExpendData/downloads/projections-methodology.pdf (accessed 20 January 2006).
11. Per capita spending for managed care enrollees is projected to be slightly higher than that for FFS enrollees over the entire projection period.
12. V. Smith et al., *Medicaid Budgets, Spending, and Policy Initiatives in State Fiscal Years 2005 and 2006*, 18 October 2005, http://www.kff.org/medicaid/7392.cfm (accessed 20 January 2006).
13. Bipartisan Commission on Medicaid Reform, *The Medicaid Commission: Report to the Honorable Secretary Michael O. Leavitt*, September 2005, available at http://www.cms.hhs.gov/FACA/10_mc.asp (accessed 20 January 2006).
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27. In last year's projection, the assumed effect of drug discounts resulted in a 2006 growth rate that was 0.5 percentage points above our forecast excluding the effects of Part D.
28. Last year, assumed utilization increases slightly offset discounts, which resulted in a slight increase in overall drug spending when Part D was incorporated into that projection.
29. Drugs that treat chronic conditions like high cholesterol and high blood pressure could be prescribed to more people as diagnosis improves and thresholds for treatment change. National Center for Health Statistics, *Health, United States, 2005, with Chartbook on Trends in the Health of Americans* (Hyattsville, Md.: NCHS, 2005); and C.D. Mullins et al., "Variability and Growth in Spending for Outpatient Specialty Pharmaceuticals," *Health Affairs* 24, no. 4 (2005): 1117–1127.
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31. Such a trend is evident in other public payers, as well as the proliferation of state programs offering home care funded through Medicaid home and community-based waivers.